S. HRG. 110–146

SENATE-HOUSE JOINT FIELD HEARING ON ISSUES FACING VETERANS IN THE RURAL AREAS OF APPALACHIA

JOINT HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS UNITED STATES SENATE

AND THE

COMMITTEE ON VETERANS' AFFAIRS HOUSE OF REPRESENTATIVES

ONE HUNDRED TENTH CONGRESS

FIRST SESSION

MAY 29, 2007

Printed for the use of the Committee on Veterans' Affairs

Available via the World Wide Web: http://www.access.gpo.gov/congress/senate

U.S. GOVERNMENT PRINTING OFFICE

37-533 PDF WASHINGTON : 2007

For sale by the Superintendent of Documents, U.S. Government Printing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512–1800; DC area (202) 512–1800
Fax: (202) 512–2250 Mail: Stop SSOP, Washington, DC 20402–0001

SENATE COMMITTEE ON VETERANS' AFFAIRS

DANIEL K. AKAKA, Hawaii, *Chairman*

JOHN D. ROCKEFELLER IV, West Virginia
PATTY MURRAY, Washington
BARACK OBAMA, Illinois
BERNARD SANDERS, (I) Vermont
SHERROD BROWN, Ohio
JIM WEBB, Virginia
JON TESTER, Montana

LARRY E. CRAIG, Idaho, *Ranking Member*
ARLEN SPECTER, Pennsylvania
RICHARD M. BURR, North Carolina
JOHNNY ISAKSON, Georgia
LINDSEY O. GRAHAM, South Carolina
KAY BAILEY HUTCHISON, Texas
JOHN ENSIGN, Nevada

WILLIAM E. BREW, *Staff Director*
LUPE WISSEL, *Republican Staff Director*

HOUSE COMMITTEE ON VETERANS' AFFAIRS

BOB FILNER, California, *Chairman*

CORRINE BROWN, Florida
VIC SNYDER, Arkansas
MICHAEL MICHAUD, Maine
STEPHANIE HERSETH SANDLIN, South Dakota
HARRY E. MITCHELL, Arizona
JOHN J. HALL, New York
PHIL HARE, Illinois
MICHAEL F. DOYLE, Pennsylvania
SHELLEY BERKLEY, Nevada
JOHN T. SALAZAR, Colorado
CIRO RODRIGUEZ, Texas
JOE DONNELLY, Indiana
JERRY MCNERNEY, California
ZACHARY T. SPACE, Ohio
TIMOTHY J. WALZ, Minnesota

STEVE BUYER, Indiana, *Ranking Member*
CLIFF STEARNS, Florida
JERRY MORAN, Kansas
RICHARD BAKER, Louisiana
HENRY BROWN, South Carolina
JEFF MILLER, Florida
JOHN BOOZMAN, Arkansas
GINNY BROWN-WAITE, Florida
MICHAEL R. TURNER, Ohio
BRIAN BILBRAY, California
DOUG LAMBORN, Colorado
GUS M. BILIRAKIS, Florida
VERN BUCHANAN, Florida

MALCOM SHORTER, *Staff Director*
JIM LARIVIERE, *Republican Staff Director*

C O N T E N T S

MAY 29, 2007

SENATORS

WITNESSES

SENATE-HOUSE JOINT FIELD HEARING ON ISSUES FACING VETERANS IN THE RURAL AREAS OF APPALACHIA

TUESDAY, MAY 29, 2007

U.S. CONGRESS,
JOINT COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The Committees met, pursuant to notice, at 10 a.m., in Founders Hall Auditorium, Kent State University-Tuscarawas, 330 University Drive, NE., New Philadelphia, Ohio, Hon. Sherrod Brown (Member of the Senate Committee on Veterans' Affairs) and Zachary Space (Member of the House Committee on Veterans' Affairs) presiding.

Present: Senator Brown and Representative Space.

OPENING STATEMENT OF HON. SHERROD BROWN, U.S. SENATOR FROM OHIO

Senator BROWN. I'm Senator Sherrod Brown, joining with Congressman Zach Space, many representatives of the veterans community, and others here this morning, and I so appreciate your all being here.

I would begin the day first by asking for a moment of silence for the 3,400 Americans who have died in the Iraq-Afghanistan, and the literally tens of thousands of Americans who have been injured, if we can start with a moment of silence. Thank you. I especially thank the veterans in the audience who are here, the veterans who will testify, the veterans' advocates who are with us. Every one of these veteran advocates have already—I believe every single one has been to see me in Washington. I assume many of them have been to see Congressman Space with his position on the Veterans' Committee. We know the importance of all of that.

I thank Gregg Andrews, the Dean of Tuscarawas Branch of Kent State University, thank him and his staff for allowing us to be here. I want to, again, especially thank those that have come from all over the state to testify today.

It's fitting, of course, that we're holding this hearing the day after Memorial Day, a date to honor our Nation's fallen men and women in uniform. We're focusing on improving services for our Nation's veterans, so we may honor them, as well. We have a full slate of issues, and a very ambitious agenda, so I'll keep my remarks brief.

The purpose of the field hearing is to hear from veterans in Ohio so that we can make better decisions in Washington that affect our

Nation's veterans. This is an official hearing. We have people from the Veterans' Committee in Washington. This is the first of its kind. To our knowledge, it's the first time the House and Senate Veterans' Committee have ever done a joint hearing outside of Washington, and we chose to do it in the heartland of sort of East Central Ohio, so that particularly veterans facing the unique problems that veterans do in rural Ohio, and rural parts of this country can be heard.

We know that the Veterans' Administration, a public system, not a privatized one. We know that the VA gives the best healthcare in the country, and in the world, when it's funded properly. We also know the President's budget fell about $4 billion short in funding what veterans' organizations have asked that we fund.

The good news is that the Congress, now the House and the Senate, are working under a recently passed budget that very closely mirrors the request of the Independent Budget. The Independent Budget was put together by all the veterans service organizations consulting with each other, and consulting with the VA. And we have very closely followed the requests of that budget.

While not everyone in this auditorium, of course, agrees on the Wars in Iraq and Afghanistan, we all agree we need to do everything we can to care and provide for our veterans, not just this year or next year, but in the decades ahead, because we know the immense costs. We're spending some $2.1 billion a week on the War in Iraq. Some estimates have shown that veterans' healthcare, because of the War in Iraq, will cost us upwards of $600 billion in the years ahead. We need to prepare for that now. It's not this year, next year. It's not even this decade, next decade only. It is costs that we need to be responsible for as elected officials, as veterans' advocates, as citizens, and as veterans, we need to prepare for, perhaps, as long as 50 years.

Ohio is home, as we know, to more than one million veterans. These proud men and women and their families have sacrificed, as we know, to serve our Nation. There are Ohioans in this room who helped to defeat tyranny in World War II. There are veterans in this room who served in the conflicts of the cold war, enabling the United States to eventually defeat totalitarianism, and we have a new group of veterans, obviously, from the post-cold war era, from Bosnia, from Afghanistan, and from two conflicts in Iraq and Kuwait.

Some of Ohio's veterans include Presidents Grant and Harrison, and Hayes and Garfield, and McKinley. Others, like John Glenn and Neil Armstrong, and Clark Gable, and General Sherman, and General Sheridan. Ohio is proud of our veterans who were our soldiers in combat today, proud of our veterans who are still living, proud of our veterans who are no longer with us, who served this country. I look forward to hearing the testimony today. We have a distinguished panel of witnesses.

Before we get started, I will run through how this will work. First, Congressman Space will deliver his opening remarks. Then we'll proceed to hear from each witness. I will introduce three of the witnesses, he will introduce three. We'll do the introduction, then the witnesses testify. Then Congressman Space and I will

take about five minutes to ask questions, and then we'll proceed to the second panel.

I want to make a handful quickly of acknowledgments of people that have been helpful. I mentioned Dean Andrews, Walter Gritzan with Administrative and Business Services with Kent State; Carla Barker, who is the Assistant to Dean Andrews; Kim Lipsky, with the Senate on Veterans' Affairs, thank you, Kim; Bill Cahill, also from Senate Veterans' Affairs Committee who's in the back; Chris Austin from House Veterans' Affairs Committee; Jean Wilson from my office. From Congressman Space's office, Ken Engstrom, Cindy Cunningham, Mike Calevski, Barb Lawrence, Shirley Farver; and from Congressman Wilson's office, Dan Craig. Also, from my office are Doug Babcock, Beth Thames, Nick Watt, Laura Pechaitis, and I believe that takes care of everybody.

So it's my pleasure to, not introduce because he's your Congressman, and in his first five months in Washington, he's done an outstanding job of convincing us to do this, convincing the Veterans' Committee in both Houses to do this first of its kind in the country hearing. A lot of the credit for that goes to Congressman Space, who has started so well, especially advocating for this region. He just took me into Dean Andrews office to advocate for something on this campus, so he doesn't miss any opportunity to fight for his district.

Congressman Space.

STATEMENT OF HON. ZACHARY T. SPACE, HOUSE REPRESENTATIVE FROM OHIO

Mr. SPACE. Thank you, Senator Brown, for the introduction, and it is a real pleasure to be here with you today. Thank you for your hard work, as well as that of your staff, and the staff of the Senate Veterans' Affairs Committee in organizing today's events. I would simply state, rather than reiterate, just thank those same folks that you singled out, with the addition of Jillian Carroll, who's behind me here on my staff in Washington, DC.

This is a truly special occasion, and I think it's the first of its kind, to my knowledge, anyway. We've managed to bring together the House and the Senate Veterans' Affairs Committees outside of Washington, DC, and we've done that here in Ohio, and right here in New Philadelphia in the heart of Ohio's 18th Congressional District. This is an indication, I believe, of the importance of the topics that we're going to be discussing today. And I am, indeed, delighted to be back here in New Philadelphia, just a few miles from my hometown of Dover.

A special thank you, again, to Kent State University for allowing us to use these facilities. We very much appreciate their hospitality. Specifically, I'd like to thank Dean Gregg Andrews, Walt Gritzan, and Carla Barker, along with the rest of the staff, and the Tuscarawas campus community for being so accommodating and giving us the run of the place.

Kent State has a special place in my heart. This, without question, serves as one of our most precious assets here in Tuscarawas County. It has given many, literally thousands, of young, bright, aspiring students the opportunity to further their education. Some of those bright, aspiring students are family members of mine, and

we, in my family, certainly appreciate the value that this regional campus brings to our community.

It's also my privilege to be in the company of eight distinguished witnesses today. I'm very much looking forward to hearing your testimony, gentlemen, and I look forward to engaging in a question and answer exchange, as well.

I'd like to take the opportunity to recognize the members of my Veterans Advisory Board, many of whom are here today. I'm indebted to these men and women for their commitment in assisting me as I advocate for the needs of our Nation's veterans, and I cannot think of a better way, to more specifically advocate on behalf of Ohio's 18th District's veterans than to ask some of Ohio 18 veterans where they stand. I will rely upon the Vets Advisory Board that we created in the coming weeks, and months, to give their informed opinions, as they've already begun to do. I know I will continue to ask for their input on other important issues, as well.

Can I ask those members of the Veterans Advisory Committee that we've created to please stand, and be recognized. Thank you, ladies and gentlemen. Can we have a round of applause for them, please.

(Applause.)

Mr. SPACE. They have traveled here to New Philadelphia from all parts of the 18th District, some taking more than 3 hours to get here today, so they should be commended, and I'd like to thank them for their work on behalf of our District's veterans.

Finally, I'd like to thank the audience for their attendance today. I appreciate your interest in the issues facing rural veterans, and I appreciate you taking the time out of your day to join us here this morning. I hope we all find this event to be a useful exchange of information, as well as a productive forum for identifying specific problems that rural veterans are facing, as well as crafting solutions. My personal goal is to translate the ideas we hear today into legislative fixes back in Washington.

A significant number of my constituents in Ohio's 18th District are veterans, which is why I was eager to serve on this Committee. A large number of our veterans live in rural areas around the country. I repeated hear from these rural veterans about the difficulties they have in accessing VA services and care. Ohio 18 is lucky enough to have a VA Medical Center in Chillicothe; however, that VAMC is about 159 miles from where we sit today. The closest VAMC for folks here in New Philadelphia is the Cleveland facility, and that's about 72 miles from where we sit. After that, the next closest facility is in Pittsburgh. And we are lucky enough to have a CBOC here in New Philadelphia, but, of course, those CBOCs do not have the same capabilities as full-fledged hospitals.

I plan on working with the VA to expand their services here in the 18th District. I know that will be a long, and very difficult battle, but I think that what we'll hear today will convince many that these steps are necessary to better serve our rural veterans.

I'm also concerned that rural veterans are putting off their doctors' visits because it is such a hassle to get to their doctors. I'm afraid that by skipping check-ups thought to be non-essential, veterans are suffering in the long-term by not seeking preventative care. Often, it's too late when a medical emergency occurs.

I know Mr. Carson can speak to the problems that non-VA hospitals face when they open their doors to veterans, too. In emergencies, our veterans need immediate care. They do not have the luxury of traveling over an hour to a VA facility. Our private hospitals have done their best to care for these veterans in their times of need, but they've done so without the assurance that they'll be reimbursed by the VA after-the-fact. I look forward to discussing both this problem, and solutions to it.

And, finally, I'm also concerned that as gas prices continue to shoot through the roof, it's become increasingly more difficult for rural veterans who, again, drive long distances, to afford trips to the VA facilities. The current mileage reimbursement rate of 11 cents per mile comes nowhere near the $3.30 plus cost of gasoline per gallon. I believe this must be addressed, as well.

Again, I'd like to thank you all for coming today, and I'd like to turn it back over to Senator Brown to introduce our first witness today on our first panel.

Senator Brown.

Senator BROWN. Thank you, Congressman Space. Our first witness will be Frank Anderson. Frank has been an advocate for veterans as long as I can remember, comes to my office at least once a year. I see him in Cleveland from time to time. He grew up in Cleveland, joined the Armed Forces in 1976, was injured in a training exercise, I believe at Fort Jackson, South Carolina. He has advocated for paralyzed veterans ever since. He and his wife, Joanna, wife of 34 years, have raised five children. He's always been there as an advocate, and always will be there as an advocate. We appreciate so much what he's done for veterans, generally, and specifically for the Paralyzed Veterans of America.

Mr. Anderson.

STATEMENT OF FRANK ANDERSON, GOVERNMENT RELATIONS DIRECTOR, BUCKEYE CHAPTER, PARALYZED VETERANS OF AMERICA

Mr. ANDERSON. Thank you, Mr. Chairman. Mr. Chairman, Members of the Committee, on behalf of the Buckeye Chapter of Paralyzed Veterans of America, I'd like to thank you for the opportunity to testify before you today on issues facing veterans who live here in Ohio, and surrounding states. The challenges facing veterans here, particularly with regards to healthcare, are not uniquely different to many of the other areas of the country. However, if the VA can figure out the best ways to address them here, they can certainly apply those actions across the board.

Due to the broad areas of possibilities, I will limit my comments to a few key areas that we believe require the greatest focus, and that are of the utmost importance. My comments will focus on the broader healthcare concern, specifically for rural veterans. I will also address our concerns about VA long-term care services, specifically for Operation Enduring Freedom, and Operation Iraqi Freedom veterans, as well as for veterans with spinal cord injuries or dysfunction. Finally, I will comment on veterans' benefits issues, particularly for members of the National Guard and Reserves.

Given the attention that these Committees are faced on the issues of access to healthcare for rural veterans, it is only appro-

priate that this joint hearing be held in the state with many veterans who live in rural areas. PVA recognizes that there is no easy solution to meeting the needs of these veterans who live in rural areas. These veterans were not originally the target of population of men and women that the VA expected to treat. However, the VA decision to expand to an outpatient network through the community-based outpatient clinics reflected the growing demand on the VA systems from veterans outside of typical urban or suburban settings.

However, PVA remains concerned that in addressing the problems of access for these veterans, the long-term viability of the VA healthcare system may be threatened.

PVA members rely on the direct services provided by the VA healthcare facilities, recognizing the fact that they do not always live close to the facilities. The services provided by the VA, particularly specialized services like spinal cord injury care, are unmatched in the private sector. If a larger pool of veterans was sent into the private sector for healthcare, the diversity of services and expertise in different fields is placed in jeopardy.

Ultimately, PVA has a serious concern about any attempts to give the VA additional leverage to broaden the contracting out of healthcare services to veterans in geographically remote or rural areas. If you review the early stages of PVA's Project HERO, it is apparent that is a direction that some VA senior leadership would like to go. PVA adamantly opposes any effort to privatize the VA healthcare system, turning it into an insurer of care, and not a provider of care. Privatization is ultimately a means for the Federal Government to shift its responsibility of caring for the men and women who serve.

PVA believes that any broader contracting out of healthcare service would almost certainly lead to a diminution of established quality, safety, and continuity of VA care. It is important to know that VA's specialized healthcare programs authorized by Congress, and designed expressly to meet the needs of combat-wounded and ill veterans, such as the blind rehabilitation centers, prosthetic and sensory aid programs, readjustment counseling, polytrauma and spinal cord injury centers, the centers for war-related illnesses, and the National Center for Post-Traumatic Stress Disorder, as well as several others, would be irreparably affected by the loss of service-connected veterans to the private sector. The VA's medical and prosthetic research program, designed to study and, hopefully, overcome the ills of disease and injury consequent to military service, would lose focus and purpose. Additionally, Title 38, U.S. Code, Section 1706(b)(1), requires VA to maintain the capacity of these specialized Medical programs, and not let their capacity fall below that which existed at the time when Public Law 104–262 was enacted.

Furthermore, veterans who are sent out to a private sector for care would lose many safeguards built into the VA system, through its patient safety program, evidence-based medicine, electronic medical records, and medication verification program. These unique VA features culminate in the highest quality care available, public or private. Loss of these safeguards, that are generally not available in private sector systems, would equate to diminished

oversight and coordination of care, and ultimately may result in lower quality of care for those who deserve it most.

Current law limits VA in contracting for private healthcare services to instances in which VA facilities are incapable of providing necessary care to a veteran; when VA facilities are geographically inaccessible to a veteran for necessary care; when medical emergency prevents a veteran from receiving care in a VA facility; to complete an episode of VA care; and for certain specialty examinations to assist VA in adjudicating disability claims. The VA could better meet the demands of rural veterans through more judicious application of its fee-for-service program.

We also believe that the VA could address the needs of rural veteran through broad applications of the "hub-and-spoke" principle. A veteran can get his or her basic care at a community-based outpatient clinic (CBOC). However, if the veteran requires more intensive care, or a special procedure, he or she can be referred to a larger VA medical center. This would ensure the veteran continues to get the best quality care provided by the VA, thereby maintaining the viability of the system.

Finally, we realize that it is an extremely difficult task to establish a standard for when a veteran's home is considered to be rural. Attempts to define "geographically inaccessible" have proven to be a very subjective effort. Access to VA healthcare is subject not only to population density or distance, but time, as well.

PVA believes that one possible way to address the concerns of rural veterans is to correct the mileage reimbursement inequity that currently exists. It is wholly unacceptable that veterans have to live with the 11 cents per mile reimbursement rate that the VA currently provides, when all federal employees receive 48 cents per mile. In fact, PVA believes that some of the difficulty in providing care to veterans in limited access areas, particularly rural areas, might be eliminated with a sensible reimbursement rate.

We believe that veterans will be less likely to complain about access issues as a result of their geographic location if they know that they would not have to put the majority of the travel expense out of their own pocket. This is a change that has been long overdue, and we urge the Committee and all of Congress to take immediate action to correct this inequity.

In the end, we believe that in order for the VA to best meet this need, adequate funding needs to be provided for VA healthcare in a timely manner. As we previously stated, placing the VA in the position it has dealt with for many years because Congress continues to wrangle over federal budgets, does not prepare the VA to properly meet demand, including demand in rural areas.

In long-term care, one of the primary concerns for PVA and its membership is access to long-term care services in the VA. We have particular concerns about long-term care options for veterans of the newest conflicts in Iraq and Afghanistan. PVA believes that the age-appropriate VA non-institutional and institutional long-term care programming for young OEF and OIF veterans must be a priority for veterans and their committees. New VA non-institutional and institutional long-term care programs must come on line, and existing programs must be re-engineered to meet the various needs of a younger veterans population.

VA non-institutional long-term care program must be required to assist the younger injured veterans with catastrophic disabilities who need a wide range of support services, such as personal attendant services, programs to train attendants, peer support programs, assistive technology, hospital-based home care teams that are trained to treat and monitor specific disabilities, and transportation services. These younger veterans need expedited access to VA benefits, such as VA's Home Improvement/Structural Alteration Grant, and VA's adaptive housing, and auto programs.

Senator BROWN. Mr. Anderson, could you try to summarize your testimony? You've gone beyond the time, but if you can sort of summarize the end.

Mr. ANDERSON. Yes, sir.

Senator BROWN. Thank you.

Mr. ANDERSON. We see that our veterans in rural areas do need access to the system and long-term care, and operation of VA so that they can address these needs, and our older veterans. And we look forward to working with the VA and its staff to make sure that our veterans are receiving timely and quality care.

[The prepared statement of Mr. Anderson follows:]

PREPARED STATEMENT OF FRANK ANDERSON, GOVERNMENT RELATIONS DIRECTOR, BUCKEYE CHAPTER, PARALYZED VETERANS OF AMERICA

Mr. Chairman and Members of the Committees, on behalf of the Buckeye Chapter of Paralyzed Veterans of America (PVA) I would like to thank you for the opportunity to testify before you today on the issues facing veterans who live here in Ohio and surrounding states. The challenges facing veterans here, particularly with regards to health care, are not uniquely different to many other areas of the country. However, if the VA can figure out the best way to address them here, they can certainly apply those actions across the board.

Due to the broad array of possibilities, I will limit my comments to a few key areas that we believe require the greatest focus and that are of the utmost importance. My comments will focus on broader health care concerns, specifically for rural veterans. I will also address our concerns about VA long-term care services, specifically for Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) veterans as well as for veterans with spinal cord injury or dysfunction. Finally, I will comment on veterans' benefits issues, particularly for members of the National Guard and Reserves.

RURAL HEALTH CARE

Given the attention that these Committees have placed on the issue of access to health care for rural veterans, it is only appropriate that this joint hearing be held in a state with many veterans who live in rural areas. PVA recognizes that there is no easy solution to meeting the needs of veterans who live in rural areas. These veterans were not originally the target population of men and women that the VA expected to treat. However, the VA decision to expand to an outpatient network through the community-based outpatient clinics reflected the growing demand on the VA system from veterans outside of typical urban or suburban settings.

However, PVA remains concerned that in addressing the problem of access for these veterans, the long-term viability of the VA health care system may be threatened. PVA members rely on the direct services provided by VA health care facilities recognizing the fact that they do not always live close to the facility. The services provided by VA, particularly specialized services like spinal cord injury care, are unmatched in the private sector. If a larger pool of veterans is sent into the private sector for health care, the diversity of services and expertise in different fields is placed in jeopardy.

Ultimately, PVA has serious concerns about any attempt to give the VA additional leverage to broaden contracting out of health care services to veterans in geographically remote or rural areas. If you review the early stages of VA's Project HERO, it is apparent that this is a direction that some VA senior leadership would like to go. PVA adamantly opposes any effort to privatize the VA health care system, turning it into an insurer of care and not a provider of care. Privatization is ultimately

a means for the Federal Government to shift its responsibility of caring for the men and women who served.

PVA believes that any broader contracting out of health care services would almost certainly lead to a diminution of established quality, safety and continuity of VA care. It is important to note that VA's specialized health care programs, authorized by Congress and designed expressly to meet the needs of combat-wounded and ill veterans, such as the blind rehabilitation centers, prosthetic and sensory aid programs, readjustment counseling, polytrauma and spinal cord injury centers, the centers for war-related illnesses, and the national center for post-traumatic stress disorder, as well as several others, would be irreparably affected by the loss of service-connected veterans to the private sector. The VA's medical and prosthetic research program, designed to study and hopefully overcome the ills of disease and injury consequent to military service, would lose focus and purpose. Additionally, Title 38, United States Code, section 1706(b)(1) requires VA to maintain the capacity of these specialized medical programs, and not let their capacity fall below that which existed at the time when Public Law 104–262 was enacted.

Furthermore, veterans who are sent out to the private sector for care would lose the many safeguards built into the VA system through its patient safety program, evidence-based medicine, electronic medical records and medication verification program. These unique VA features culminate in the highest quality care available, public or private. Loss of these safeguards, that are generally not available in private sector systems, would equate to diminished oversight and coordination of care, and ultimately may result in lower quality of care for those who deserve it most.

Current law limits VA in contracting for private health care services to instances in which VA facilities are incapable of providing necessary care to a veteran; when VA facilities are geographically inaccessible to a veteran for necessary care; when medical emergency prevents a veteran from receiving care in a VA facility; to complete an episode of VA care; and, for certain specialty examinations to assist VA in adjudicating disability claims. The VA could better meet the demands of rural veterans through more judicious application of its fee-for-service program.

We also believe that the VA could address the needs of rural veterans through broad application of the "hub-and-spoke" principle. A veteran can get his or her basic care at a community-based outpatient clinic (CBOC). However, if the veteran requires more intensive care or a special procedure, he or she can then be referred to a larger VA medical center. This would ensure that the veteran continues to get the best quality care provided directly by the VA, thereby maintaining the viability of the system.

Finally, we realize that it is an extremely difficult task to establish a standard for when a veteran's home is considered to be rural. Attempts to define "geographically inaccessible" have proven to be a very subjective effort. Access to VA health care is subject not only to population density or distance, but time as well.

PVA believes that one possible way to address the concerns of rural veterans is to correct the mileage reimbursement inequity that currently exists. It is wholly unacceptable that veterans have to live with the 11 cents per mile reimbursement rate that the VA currently provides when all Federal employees receive 48 cents per mile. In fact, PVA believes that some of the difficulty in providing care to veterans in limited access areas, particularly rural areas, might be eliminated with a sensible reimbursement rate. We believe that veterans would be less likely to complain about access issues as a result of their geographic location if they know that they will not have to foot the majority of the travel expense out of their own pocket. This is a change that has been long overdue, and we urge the Committees and all of Congress to take immediate action to correct this inequity.

In the end, we believe that in order for the VA to best meet this demand, adequate funding needs to be provided for VA health care in a timely manner. As we previously stated, placing the VA in the position it has dealt with for many years because Congress continues to wrangle over Federal budgets, does not prepare the VA to properly meet demand, including demand in rural areas.

LONG TERM CARE

One of the primary concerns for PVA and its membership is access to long-term care services in the VA. We have particular concerns about the long-term care options for veterans of the newest conflicts in Iraq and Afghanistan. PVA believes that age-appropriate VA non-institutional and institutional long-term care programming for young OEF/OIF veterans must be a priority for VA and these Committees. New VA non-institutional and institutional long-term care programs must come on line and existing programs must be re-engineered to meet the various needs of a younger veteran population.

VA's non-institutional long-term care programs will be required to assist younger injured veterans with catastrophic disabilities who need a wide range of support services such as: personal attendant services, programs to train attendants, peer support programs, assistive technology, hospital-based home care teams that are trained to treat and monitor specific disabilities, and transportation services. These younger veterans need expedited access to VA benefits such as VA's Home Improvement/Structural Alteration (HISA) grant, and VA's adaptive housing and auto programs so they can leave institutional settings and go home as soon as possible. PVA also believes that VA's long-term care programs must be linked to VA's new polytrauma centers so that younger veterans can receive injury specific annual medical evaluations and continued access to specialized rehabilitation, if required, following initial discharge.

VA's institutional nursing home care programs must change direction as well. Nursing home services created to meet the needs of aging veterans will not serve young veterans well. As pointed out in The Independent Budget for FY 2008, VA's Geriatric and Extended Care staff must make every effort to create an environment for young veterans that recognizes they have different needs. Younger catastrophically injured veterans must be surrounded by forward-thinking administrators and staff that can adapt to youthful needs and interests. The entire nursing home culture must be changed for these individuals, not just modified. For example, therapy programs, living units, meals, recreation programs, and policy must be changed to accommodate young veterans entering the VA long-term care system.

PVA is also concerned that many veterans with spinal cord injury and disease are not receiving the specialized long-term care they require. VA has reported that over 900 veterans with SCI/D are receiving long-term care outside of VA's four SCI/D designated long-term care facilities. However, VA cannot report where these veterans are located or if their need for specialized medical care is being coordinated with area VA SCI/D centers.

Today's VA SCI/D long-term care capacity cannot meet current or future demand for these specialized services. Waiting lists exist at the four designated SCI/D facilities.

Currently, VA only operates 125 staffed long-term care (nursing home) beds for veterans with SCI/D. These facilities are located at: Brockton, Massachusetts (30 beds); Castle Point, New York (15 beds); Hampton, Virginia (50 beds); and 30 beds at the Hines Residential Care Facility in Chicago, Illinois. Geographic accessibility is a major problem because none of these facilities are located west of the Mississippi River. New designated VA SCI/D long-term care facilities must be strategically located to achieve a national geographic balance to long-term care to meet the needs of veterans with SCI/D that do not live on the East coast of the United States.

VA's own Capital Asset Realignment for Enhanced Services (CARES) data for SCI/D long-term care reveals a looming gap in long-term care beds to meet future demand. VA data projects an SCI/D long-term care bed gap of 705 beds in 2012 and a larger bed gap of 1,358 for the year 2022. VA's proposed CARES SCI/D long-term care projects would add needed capacity (100 beds) but are very slow to come on line. CARES proposes adding 30 SCI/D LTC beds at Tampa, Florida; 20 beds at Cleveland, Ohio; 20 beds at Memphis, Tennessee; and 30 beds at Long Beach, California. The CARES Tampa project is currently under construction but is not scheduled to open for another 2 years and the Cleveland project is currently in the design phase but remains years from completion. The Buckeye Chapter is particularly pleased that the Cleveland/Brecksville project is moving forward. This will prove to be a critical facility for meeting the long-term, specialized care needs of PVA members. Finally, the Memphis and Long Beach projects have not even entered the planning stage at this time.

Methods for closing the VA SCI/D long-term care bed gap and resolving the geographic access service issue are part of the same problem for PVA. VA's Construction Budget for 2008 includes plans for new 120 bed VA nursing homes to be located in Las Vegas, Nevada and at the new medical center campus in Denver, Colorado. Also, VA has announced construction planning of a new 140 bed nursing home care unit in Des Moines, Iowa.

Mr. Chairman, PVA needs your support to ensure VA construction planning dedicates a percentage of beds at each new VA nursing home facility for veterans with SCI/D. PVA requests that Congress mandate that VA provide for a 15 percent bed set-aside in each new VA nursing home construction project to serve veterans with SCI/D and other catastrophic disabilities. These facilities will require some special architectural design improvements and trained staff to meet veteran need. However, much of the design work has already been accomplished by PVA and VA's Facility Management team. This Congressional action will help reduce the SCI/D bed-gap and help meet the current and future demand for long-term care. While a 15 per-

cent bed allocation in new VA nursing home construction plus the proposed CARES LTC projects do not solve the looming bed gap problem in the short run it is a good first step and these additions will improve VA's SCI/D long-term care capacity in the western portion of the country.

Public Law 109–461 required VA to develop and publish a strategic plan for long-term care. PVA congratulates Congress on understanding the importance of this issue to ensure that America's catastrophically disabled and aging veteran population is well cared for. During the organization of VA's strategic long-term care plan PVA calls on VA and Congress to pay careful attention to the institutional and non-institutional long-term care needs of veterans with SCI/D and other catastrophic disabilities. We request that PVA and other veterans service organizations have an opportunity to provide input and assist VA as it moves forward in the development of this important document.

In the past, and even today, many veterans with spinal cord injury or disease and other catastrophic disabilities were shunned from admittance to both VA and community nursing homes because of their high acuity needs. PVA believes that catastrophic disability must never be grounds to refuse admittance to VA or contract VA long-term care services. PL 109–461 requires VA to include data on, "the provision of care for catastrophically disabled veterans; and the geographic distribution of catastrophically disabled veterans." This information is critical if VA's strategic plan is to adequately address the needs of this population.

VETERANS BENEFITS

PVA realizes that there is a desire to fix the problems with the claims backlog in the Veterans Benefits Administration (VBA) immediately. However, we must emphasize that there is no quick fix that can be implemented to fix these problems. The backlog has become too extensive to simply place some arbitrary requirement on VBA that will not address the long-term situation.

We believe that the VA cannot continue to make changes in VBA, and specifically the claims process, sporadically. We believe that the only way the VA will ever get a handle on the claims process, the backlog, and associated problems is to pick a specific date to make major changes. It cannot implement change piecemeal.

We realize that fixing the discharge and subsequent claims process is no easy task. However, we should not be shooting at individual targets to attempt to fix the overall problem. It will take innovative approaches focused on the broader system.

In the end, we believe that many of the problems in the Veterans Benefits Administration are centered on proper training and accountability. Without uniform training across all of VBA on the standards established in regulations, problems will continue to arise and the claims backlog will continue to grow. Furthermore, it is absolutely essential that VBA personnel at all levels be held accountable for their own actions and the actions of their subordinates. Although we continue to advocate for adequate resources and additional staff, these steps will not go far enough if training and accountability are not a major component. Similarly, we recognize that veterans service organizations have a commensurate obligation to properly train and supervise their personnel.

Finally, despite efforts by VA to address all of the needs and concerns of OEF/OIF veterans, another population of these men and women still continue to receive lesser service than their active duty counterparts—National Guard and Reserves. We have testified many times in the past as to the importance of effective outreach, particularly for the National Guard and Reserves. It is only appropriate that National Guard and Reserve servicemembers be handled in the same way as active duty servicemembers. The level of service being required of these men and women in current operations more than justifies the need to inform them of all of the health care and benefits services available.

Mr. Chairman and Members of the Committees, the Buckeye Chapter stands ready to assist you in any way to address the needs of veterans here in Ohio and across America. It is vitally important that we work together to ensure that the best improvements are made to benefit veterans and their families.

Thank you again for the opportunity to testify. I would be happy to answer any questions that you might have.

Senator BROWN. Thank you. And understand, everyone's written statement will be in the record in its entirety. These statements will be used as we use Committee hearings in Washington to move forward, as Congressman Space said, on legislative efforts. One of the efforts you mentioned, Mr. Anderson, on the mileage reim-

bursement should have been fixed a long time ago. I am convinced it will be fixed in this Congress. Senator Tester, and I, and others from Montana have worked on legislation, and we will move forward on that, so thank you for that.

Mr. Larry Moore is our next witness. Mr. Moore was in active duty as a U.S. Navy CB in Vietnam from 1968 to 1970, State Legislative Impact Chairman of the Veterans of Foreign Wars, Department of Ohio. He's Director of the Richland County Veterans Service Commission, and he spoke a couple of days ago with my mother in Mansfield.

So, Mr. Moore, nice to have you with us. Thank you.

STATEMENT OF LARRY MOORE, STATE LEGISLATIVE DIRECTOR, DEPARTMENT OF OHIO, VETERANS OF FOREIGN WARS OF THE UNITED STATES

Mr. MOORE. Well, thank you. Thank you, ladies and gentlemen. Senator Brown, Representative Space, I am pleased to be here before you today representing the 139,000 men and women of the Veterans of Foreign Wars Department of Ohio, and our Ladies Auxiliary.

The first issue to be addressed today is access to the VA healthcare system by veterans living in rural areas. Continuing to expand VA community-based outreach clinics by either leasing existing space, or new construction, should be one of the priorities of the VA and Congress. The goal of these clinics is to bring healthcare to a local level for our veterans, and expanding these types of facilities in rural areas only makes good sense.

The community-based outpatient clinics provide basic healthcare needs, with an emphasis on preventative measures to screen and test for such things as diabetes, heart conditions, prostate cancer, and mental health conditions. The clinics staff, registered nurses, and licensed social case workers, who provide medical and mental healthcare covering an average of six counties both in the clinic office, and at the veteran's personal home.

Studies have shown that the VA healthcare is less costly than that in the private sector. Expansion of these clinics would potentially save the taxpayers millions of dollars, and continue to bring medical treatments on a local level, rather than the past practice of a regional VA medical center. If a primary doctor feels a veteran needs to see a specialist, then he will make an appointment at one of the VA medical centers; however, this causes a problem for veterans living in rural areas, because these centers can be hundreds of miles from his home, with no public transportation available. This forces him to either provide his own transportation, rely on a family member or friend to transport him for his appointment.

The VA does provide gas mileage reimbursement to VA medical facilities for appointments, but not at the present IRS rate of 48.5 cents per mile currently allowed to any businessman, county, state, or federal employee. The VA allows only 11 cents per mile. Most veterans I work with find this to be a complete joke, and will not even bother filling out the paperwork for the reimbursement. Not only do I agree this is a complete joke, but I also feel it is a total insult to those who honorably served this country.

I would ask Congress to investigate and find a solution that allows that reflects today's high gasoline cost, not that of 1960. The majority of the veterans must make multiple trips to these regional VA medical centers. For example, on average, it takes three trips for hearing aids, dental crowns, and eyeglasses, and cancer treatments of radiation and chemotherapy can take ten trips. To someone living in an already economically depressed region, can you imagine the difficulty and personal expense to the veteran and his family? Is this what Congress meant in 1996 when legislation was passed, stating that all honorably discharged veterans would be eligible for VA healthcare as long as you can get there.

The VA Health Administration has developed a program to provide more home care for patients. The program, which would allow practitioners to manage more patients, is called Care Coordination. This program would eliminate the need for frequent visits by patients to VA medical facilities. Through the Internet, telephone lines, and telemedicine units, such as the glucometer devices, VHA medical professionals will remotely observe patients with multiple chronic conditions, such as mental health, diabetes, congestive heart failure, and spinal cord injury.

One such device, called a Telebuddy, attaches to a patient's phone jack. The patient responds to questions about how he is feeling, and whether he took his medication. If there is no problem, the device flashes green. If the patient does not answer, the patient's case manager is notified. This is an extremely useful tool to those VA staffers who make these house calls, especially on the mental health side. These units are programmed to ask targeted questions that could provide early warning that the veteran's possible depression or PTSD condition may be at a level dangerous to himself, or his family.

Construction of new CBOCs, community-based outreach clinics, cannot happen over night. And in the meantime, short-term solutions need to be addressed. Some of those short-term solutions presently being considered by Congress are the following. House Resolution 92, the Veterans Timely Access to Health Care Act.

HOUSE RESOLUTION 315, THE HEALTHY VETS ACT; HOUSE RESOLUTION 339

The VFW strongly supports the intent of these types of legislation. We do have some concerns, however, with the potential for overuse of contracting care, but there are certainly areas where its use is proper. Fee-basis care is more expensive than that of the VA, and we believe that it would do great harm to those veterans who elect to stay in the high-quality VA healthcare system by taking away funding for the system as a whole.

HOUSE RESOLUTION 1426

The VFW strongly opposes this legislation, which would allow any veteran to elect to receive contracted care whenever they choose. Although this legislation aims to expand the coverage available to veterans, it would only dilute the quality and quantity of the services provided to new and existing veterans today, and in the future. That is unacceptable.

DRAFT BILL, THE RURAL VETERANS HEALTH CARE ACT

The VFW supports this bill, which would make changes and improvements to the availability of healthcare for rural area veterans. With over 44 percent of the returning servicemembers living in rural areas, the access problem they, and all veterans, face are of increasing importance. This legislation acknowledges that, and we are happy to support it.

Lastly, I would ask Congress to bear in mind the long-term cost of care for those wounded servicemembers returning from the War in Iraq. Head and limb injuries are signature wounds of this war, because Iraqi insurgents have made the IED their weapon of choice. Modern armor and rapid care mean that most of the injured survive, but many live with traumatic brain injuries and amputations.

I would point out the hidden danger with respect to head injuries. Between January 2003 and April of 2006, of the 692 traumatic brain injuries treated at Walter Reed Army Hospital, nearly 90 percent had non-penetrating head injuries from the sheer concussion of the blast from an IED. Returning combat veterans may not know they suffer such a wound, and since this type of injury isn't immediately apparent or visible to the naked eye, medical personnel may miss the diagnosis if the proper screening methods are not used.

Coupled with TBI-type injuries, there's Post Traumatic Stress Disorder, better known as PTSD. Many servicemembers have had multiple deployments to combat zones, and studies show there is a 50 percent greater chance these combat veterans may develop issues involving PTSD; and in most cases, these are young men and women with serious service-connected disabilities who will need expensive care for many years.

My hope is more emphasis will be put on screening for TBI, depression, and PTSD. I do not wish to have another sobbing mother in my office personally blaming herself for her 20-year-old Marine reservist son's suicide, who just returned from a tour in Iraq.

The VA system may not be perfect, but when adequately funded in a timely manner by Congress, the ability to deliver quality healthcare and reduce lengthy claims waiting periods for service-connected disabilities could be achieved.

Senator Brown, Representative Space, this concludes the VFW's testimony, and I would be happy to answer any questions you may have. Thank you.

[The prepared statement of Mr. Moore follows:]

PREPARED STATEMENT OF LARRY D. MOORE, LEGISLATIVE CHAIRMAN, DEPARTMENT OF OHIO, VETERANS OF FOREIGN WARS OF THE UNITED STATES

Senator Brown and Representative Space:

I am pleased to be here before you today representing the one hundred and thirty-nine thousand men and women of the Veterans of Foreign Wars Department of Ohio and our Ladies Auxiliary.

The first issue to be addressed today is access to the VA healthcare system by veterans living in rural areas. Continuing to expand VA community based outreach clinics by either leasing existing space or new construction should be one of the priorities of the VA and Congress. The goal of these clinics is to bring health care to a local level for our veterans, and expanding these types of facilities into rural areas only makes good sense. The Community Based Outpatient Clinics provide basic healthcare needs, with an emphasis on preventive measures to screen and test for

such things as diabetes, heart conditions, prostate cancer, and mental health conditions. The clinics staff registered nurses and licensed social case workers, who provide medical and mental healthcare covering an average of six counties both in the clinic office and at the veterans personal home. Studies have shown that VA healthcare is less costly than in the private sector. Expansion of these clinics would potentially save the taxpayers millions of dollars, and continue to bring medical treatments on a local level rather than the past practice of a regional VA medical center. If the primary doctor feels the veteran needs to see a specialist, then he will make an appointment at one of the VA medical centers; however, this causes a problem for veterans living in rural areas, because these centers can be hundreds of miles from his home with no public transportation available. This forces him to either provide his own transportation or rely on a family member or a friend to transport him for his appointment.

The VA does provide gas mileage reimbursement to VA medical facilities for appointments, but not at the present IRS rate of 48 cents per mile currently allowed to any businessman or county, state or Federal employee—the VA allows veterans only 11 cents per mile. Most veterans I work with find this to be a complete joke, and will not even bother filling out the paperwork for the reimbursement. Not only do I agree that this is a complete joke, but also I feel this is a total insult to those who honorably served this country. I would ask Congress to investigate, and find a solution to allow a gas reimbursement that reflects today's high gasoline cost, not that of 1960. The majority of veterans must make multiple trips to these regional VA medical centers—for example on average it takes three trips for hearing aids, dental crowns, and eyeglasses, and cancer treatments of radiation and chemotherapy can take ten trips. To someone living in an already economically depressed region, can you imagine the difficulty and personal expense to the veteran and his family?! Is this what Congress meant in 1996 when legislation was passed, stating that all honorably discharged veterans were eligible for VA health care as long you can get there?!

The VA Health Administration has developed a program to provide more home care to patients. The program, which would allow practitioners to manage more patients, is called care coordination. This program would help eliminate the need for frequent visits by patients to VA medical facilities. Through the Internet, telephone lines and telemedicine units such as glucometer devices, VHA medical professionals will remotely observe patients with multiple chronic conditions such as mental illness, diabetes, congestive heart failure, and spinal cord injury. One such device, called a Telebuddy, attaches to a patient's phone jack. The patient responds to questions about how he is feeling and whether he took his medication. If there is no problem, the device flashes green. If the patient does not answer, the patient's case manager is notified. This is an extremely useful tool to those VA staffers who make these house calls, especially on the mental health side, these units are programmed to ask targeted questions that could provide early warning that the veterans possible depression or PTSD condition maybe at a level dangerous to himself or his family.

Construction of new CBOCs cannot happen over night, and in the meantime, short term solutions need to be addressed. Some of those short-term solutions presently being considered by Congress are the following:

H.R. 92, THE VETERANS TIMELY ACCESS TO HEALTH CARE ACT; H.R. 315, THE HEALTHY VETS ACT; H.R. 339

The VFW strongly supports the intent of these types of legislation. We do have concerns, however, with the potential for overuse of contracting care but there are certainly areas where its use is proper. Fee-basis care is more expensive than that of the VA, and we believe that it would do great harm to those veterans who elect to stay in the high-quality VA health care system by taking away funding for the system as a whole.

H.R. 1426

The VFW strongly opposes this legislation, which would allow any veteran to elect to receive contracted care whenever they choose. Although this legislation aims to expand the coverage available to veterans, it would only dilute the quality and quantity of the services provided to new and existing veterans today and into the future. That is unacceptable.

DRAFT BILL, THE RURAL VETERANS HEALTH CARE ACT

The VFW supports this bill, which would make changes and improvements to the availability of health care for rural veterans. With over 44 percent of returning

servicemembers living in rural areas, the access problems they and all veterans face are of increasing importance. This legislation acknowledges that, and we are happy to support it.

Lastly, I would ask Congress to bear in mind the long-term cost of care for those wounded servicemembers returning from the War on Terror. Head and limb injuries are signature wounds of this war, because Iraqi insurgents have made the IED their weapon of choice. Modern armor and rapid care mean that most of the injured survive, but many live with traumatic brain injuries and amputations. I would point out the hidden danger with respect to head injuries—between January 2003 and April 2006, of the 692 traumatic brain injuries treated at Walter Reed Army Hospital, nearly 90 percent had non-penetrating head injuries from the sheer concussion of the blast from IEDs. Returning combat veterans may not know they have suffered such a wound, and since this type of injury isn't immediately apparent or visible to the naked eye, medical personnel may miss the diagnosis if the proper screening methods are not used. Coupled with TBI type injuries is Post Traumatic Stress Disorder (PTSD). Many servicemembers have had multiple deployments to combat zones, and studies now show there is a 50 percent greater chance these combat veterans may develop issues involving PTSD; and in most cases these are young men and women with serious service-connected disabilities, who will need expensive care for many years. My hope is more emphasis will be put on screening for TBI, depression, and PTSD. I do not wish to have another sobbing mother sit in my office personally blaming herself for her twenty-year old marine reservist son's suicide, who just returned from a tour in Iraq.

The VA System may not be perfect, but when adequately funded in a timely manner by Congress, the ability to deliver quality healthcare and reduce lengthy claims waiting periods for service-connected disabilities could be achieved.

Senator Brown and Representative Space, this concludes the VFW's testimony, I would be happy to answer any questions you may have.

Thank you.

Senator BROWN. Thank you very much, Mr. Moore.

George Ondick, his wife, Monica, graduated from Avon High School, a community in Lorain County where I live. He is Executive Director of AMVETS Ohio, currently the Vice President of the Ohio Veterans' Hall of Fame Foundation. He graduated from high school and entered the United States Marine Corps, was discharged in 1971.

Mr. Ondick, glad to have you. Thank you.

STATEMENT OF GEORGE ONDICK, EXECUTIVE DIRECTOR, DEPARTMENT OF OHIO, AMVETS

Mr. ONDICK. Thank you, Senator.

Mr. Chairman, Members of the Committee, I'm pleased to appear today to offer testimony on behalf of the Ohio AMVETS related to Department of Veterans' Affairs remote and rural veterans' issues.

In a 2004 study of more than 767,000 veterans by Veterans' Affairs researchers shows those in rural areas are in poorer health than their urban counterparts. The findings reported in the October American Journal of Public Health, validate the recent and ongoing VA efforts to expand healthcare for rural patients.

"We need to think about veterans who live in rural settings as a special population, and we need to carefully consider their needs when designing healthcare delivery systems," said study leader William B. Weeks, a physician and researcher with White River Junction VA Medical Center and Dartmouth Medical School. Senior author on the study was Jonathan B. Perlin, VA Acting undersecretary for health.

The study included 767,109 veterans who had used VA healthcare between 1996 and 1999. VA had then just begun setting up community-based outpatient clinics (CBOCs) to provide primary

care closer to home for rural veterans. Today, there are nearly 700 CBOCs in the VA's nationwide system, and recent recommendations from the VA's Capital Asset Realignment for Enhanced Services initiatives call for the establishment of more than 150 additional CBOCs.

Many veterans living in remote areas have found several problems on reaching the VA Medical Centers and VA Clinics; some due to their inability to obtain transportation, and others due to inability to pay for their transportation. In Ohio, most county Veterans Service Commissions will provide transportation for "qualified" veterans. However, a disabled veteran going for VA healthcare, may receive from the VA a mileage allotment of 11 cents per mile, with a $3 deductible each way. Compare that 11 cents to a VA employee receiving 48.5 cents, which is considerably more for the same trip, and no deductible. Why is there a difference? The veteran has to pay the same $3.50 for fuel, as does the VA employee.

Veterans' Affairs community-based outpatient clinics were established to change from the centralized idea of admitting many veterans to a hospital for treatment, to smaller, more localized service on an outpatient basis. This, seemingly, is much better for the patient, the family, and the VA budget. It has worked quite well until the veterans' healthcare outreach was stopped due to budget restrictions.

The VA Health Administration had an outreach program that worked quite well. The VAMCs would send a team, a doctor, nurse, technician, and an administrative clerk, to various remote areas to do routine healthcare. In southern Ohio, there were many examples; a team went to Pomeroy, 88 miles away from the Chillicothe VAMC, and Jackson, 45 miles away from the Chillicothe VAMC, as well as several other locations. In Jackson, they set up shop in a veterans service organization post. In Pomeroy, they used part of the Holzer Clinic. There were may outreach clinics in operations, until the budget problems in January 2003 caused their closing.

The VA policy on establishing VA CBOCs was established so a veteran would not have to travel over 35 miles to obtain healthcare. It was changed to 40 miles. Now the strange thing is, in northern Ohio, there are VA clinics fairly well covering all geographic areas, and only one facility is scheduled to close, and it is within the 40 mile limit.

Now, I was just reviewing the map with Mr. Montague, and the CBOCs are in a 30-mile radius; however, the drive time and distance is greater. The infrastructure in rural areas is not the same as in urban areas.

Mr. ONDICK. I'd like to correct that, and move on.

Those veterans who depended on outreach visits must now travel 80 miles or more to visit a doctor to get their treatments, and then drive back 80 miles or so. For those needing radiation, they are further transferred to Cincinnati in a van. In Cincinnati, they are given their radiation treatment, which causes great nausea, then delivered back to their vehicle for the 80 miles or more drive home. What a way to say thank you for your service.

The understandable rationale is that the VA facilities are set up in areas that will service the largest number of veterans, and thus,

being cost-effective. This put us in our present conundrum of providing for veterans's in remote and rural areas. These veterans served and sacrificed just as much as their counterparts in large populated areas. It is AMVETS' position that we need the VA medical outreach re-established for those in remote and rural areas of Ohio, and the Nation. We owe our rural veterans this service, and more.

The AMVETS is currently providing outreach to veterans in southern Ohio, filing claims on their behalf. With each claim we file, we create another access dilemma for the veterans we serve. Again, it is the AMVETS' position that we need the VA medical outreached re-established for those veterans in remote and rural areas of Ohio and this Nation. I also believe the VA created an Office of Rural Health Care, it should be funded and supported.

I would also like to take this time to reiterate the AMVETS legislative priorities for 2007, and they are as follows. I'm not going to go into great detail on this. I will headline those, because they've been brought to the Committee's attention in the past, and you have the testimony.

The President's Budget Request for VA in Fiscal Year 2008 seeks approximately $86.7 billion for veterans' benefits and services. This amounts to $39.4 billion in discretionary funding, and $44.9 billion in mandatory appropriations. In Fiscal Year 2008, AMVETS requests roughly $43.6 billion in discretionary funding.

We seek mandatory funding for VA healthcare, extended enrollment for OEF and OIF veterans, seamless transition, Post Traumatic Stress Disorder, and Traumatic Brain Injury care for our veterans, VA burial allowance, and taking care of the VA claims backlog.

I'd like to thank you for this opportunity to testify, and if you have any questions regarding these priorities, or you need additional information, you can reach me at my office. I'd like to thank you for holding this hearing, and providing us the opportunity to present testimony.

[The prepared statement of Mr. Ondick follows:]

PREPARED STATEMENT OF GEORGE ONDICK, EXECUTIVE DIRECTOR, DEPARTMENT OF OHIO, AMVETS

Mr. Chairman and Members of the Subcommittee:

I am pleased to appear today to offer testimony on behalf of Ohio AMVETS related to Department of Veterans Affairs (VA) remote and rural veterans' issues.

In a 2004 study of more than 767,000 veterans by Veterans Affairs researchers shows those in rural areas are in poorer health than their urban counterparts. The findings, reported in the October *American Journal of Public Health*, validate recent and ongoing VA efforts to expand health care for rural patients.

"We need to think about veterans who live in rural settings as a special population, and we need to carefully consider their needs when designing healthcare delivery systems," said study leader William B. Weeks, M.D., MBA, a physician and researcher with the White River Junction VA Medical Center and Dartmouth Medical School. Senior author on the study was Jonathan B. Perlin, M.D., Ph.D., VA's acting Under Secretary for Health.

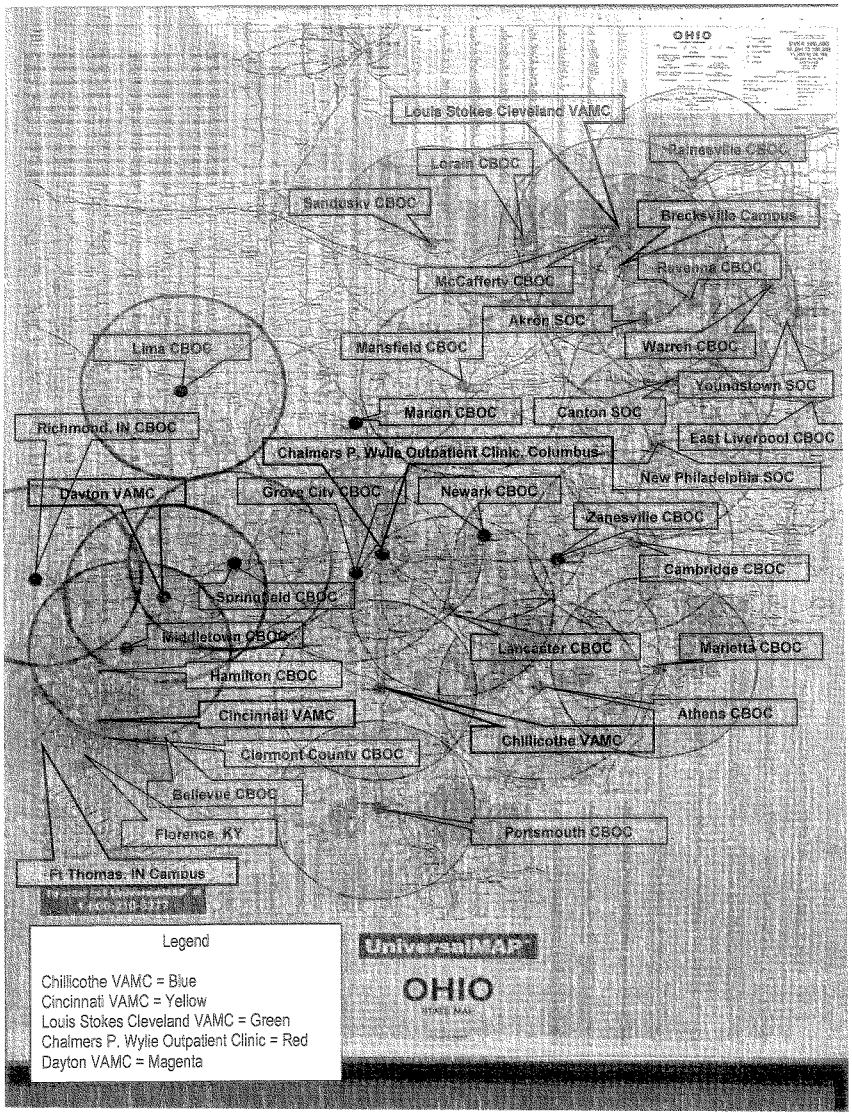
The study included 767,109 veterans who had used VA healthcare between 1996 and 1999. VA had then just begun setting up Community Based Outpatient Clinics (CBOCs) to provide primary care closer to home for rural veterans. Today there are nearly 700 CBOCs in VA's nationwide system, and recent recommendations from VA's Capital Asset Realignment for Enhanced Services (CARES) initiative call for the establishment of more than 150 additional CBOCs.

Many veterans living in remote areas have found several problems on reaching the VA Medical Centers and VA Clinics; some, due to their inability to obtain transportation, and others due to inability to pay for their transportation. In Ohio, most County Veterans Service Commissions will provide transportation for "qualified" veterans. However, a disabled veteran going for VA Healthcare, may receive from the VA mileage of 11 cents per mile with a $3 deductible each way. Compare that 11 cents to a VA employee receiving 48.5 cents which is considerably more for the same trip and no deductible. Why is there a difference? The veteran has to pay the same $3.50 for fuel as does the VA employee.

Veterans Affairs Community Based Outpatient Clinics (VA CBOCs or CBOC) were established to change from the centralized idea of admitting many veterans to a hospital for treatment, to smaller, more localized service on a outpatient basis. This seemingly is much better for the patient, the family and the VA budget. It had worked quite well until the veterans' healthcare outreach was stopped due to budget restrictions.

The VA Health Administration had an outreach program that worked quite well. The VAMCs would send a team (a doctor, nurse, technician and admin clerk) to various remote areas to do the routine healthcare. In southern Ohio, there were many examples: a team went to Pomeroy, 88 miles away from the Chillicothe VAMC, and Jackson, 45 miles away from the Chillicothe VAMC, as well as several other locations. In Jackson, they set up shop in a VSO post. In Pomeroy, they used part of the Holzer Clinic. There were many "outreach clinics" in operation, until the budget problems in January 2003 caused their closing.

The VA policy on establishing VA CBOCs was established so a veteran would not have to travel over 35 miles to obtain healthcare. It was changed to 40 miles. Now the strange thing is in northern Ohio, there are VA Clinics fairly well covering all geographic areas and only one facility is scheduled to close and it is within 40 miles of VA clinics on each side (see attached map showing VISN 10 only so the NW corner of Ohio appears uncovered). This gives us an idea of the problem. In the western portion, the Cincinnati area, there are plenty of VA facilities, many within 30 miles of one another. In remote/rural southeast Ohio, it is a different story. The CBOC program has been curtailed. There are VA CBOCs in Athens, Portsmouth and Marietta, which cover as much area as 20 facilities in other areas of Ohio. Those veterans who depended on outreach visits must now travel 80 or more miles to visit a doctor to get their treatments and then drive back 80 or so miles. For those needing radiation, they are further transferred to Cincinnati in a van. In Cincinnati, they are given their radiation treatment, which causes great nausea, then delivered back to their vehicle for the 80 miles or more drive home. What a way to say thank you for your service to our great Nation!!!



[Note: Since the map is not printed in color, the following describes the legend.]

Chillicothe VAMC = Blue
Cambridge CBOC, Lancaster, Marietta, Athens, Portsmouth.

Cincinnati VAMC = Yellow
Hamilton CBOC, Clermont County CBOC, Bellevue CBOC, Florence, KY
Ft. Thomas, IN campus.

Louis Stokes Cleveland VAMC = Green
Lorain CBOC, Painesville, Sandusky, McCafferty, Ravenna, Akron, Mansfield, Warren, Youngstown, Canton, East Liverpool, New Philadelphia.

Chalmers P. Wylie Outpatient Clinic = Red
Marion CBOC, Grove City CBOC, Newark, Zanesville.

Dayton VAMC = Magenta
Lima CBOC, Richmond IN CBOC, Sprinfield, Middletown.

The understandable rationale is that VA facilities are set up in areas that will service the largest number of veterans and thus being cost effective. This put us in our present conundrum of providing for veterans in remote/rural areas. Those veterans served and sacrificed just as much as their counterparts in large populated areas. It is AMVETS' position that we need the VA medical outreach reestablished for those in remote/rural areas of Ohio and the Nation. We owe our rural area veterans this service and more.

The AMVETS is currently providing outreach to veterans in southern Ohio, filing claims on their behalf. With each claim we file, we create another access dilemma for the veterans we serve. Again, it is AMVETS' position that we need the VA medical outreach reestablished for those in remote/rural areas of Ohio and the Nation. I also believe the VA created an Office of Rural Health Care it should be funded, and supported.

I would also like to take the time to reiterate the AMVETS legislative priorities for 2007, they are as follows:

THE DEPARTMENT VETERANS AFFAIRS (VA) FISCAL YEAR 2008 BUDGET

The President's budget request for VA in Fiscal Year (FY) 2008 seeks approximately $86.7 billion for veterans' benefits and services. This amounts to $39.4 billion in discretionary funding and $44.9 billion in mandatory appropriations. In FY 2008, AMVETS requests roughly $43.6 billion in discretionary funding.

MANDATORY FUNDING FOR VA HEALTH CARE

In May 2001, President George W. Bush signed Executive Order 13214 creating the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans (PTF). In May 2003, the PTF issued its final report and recommended that "*the Federal Government should provide full funding . . . and that full funding should occur through modifications to the current budget and appropriations process, by using a mandatory funding mechanism.*" Recent history demonstrates why Congress should pass legislation to make VA health care funding mandatory spending. In FY 2005, VA faced a $1.3 billion shortfall in spending and Congress had to include additional funding in emergency appropriations. For FY 2007, Congress failed to pass the annual VA spending bill and the department is operating under a Continuing Resolution well below FY 2007 requested levels.

EXTEND ENROLLMENT FOR OEF/OIF VETERANS

H.R. 612 and S. 383 introduced in the House of Representative and the Senate, respectively, would extend from 2 years to 5 years, following discharge or release from active duty, the eligibility period for veterans who served in combat during or after the Persian Gulf War. Continued eligibility would allow veterans to receive hospital care, medical services, or nursing home care provided by the Secretary of Veterans Affairs, notwithstanding a lack of evidence to conclude that their condition is attributable to such service. AMVETS fully supports the passage of legislation to extend the 2-year priority enrollment for OEF/OIF veterans.

SEAMLESS TRANSITION

In March 2007, GAO testified that the Department of Defense (DOD) and VA were still having problems sharing the necessary medical records the VA needed to determine whether servicemembers' medical conditions allowed participation in VA's rehabilitation activities. Congress should require the two agencies to develop electronic medical records that are interoperable, bidirectional, and standards-based. Congress should also require DOD to conduct mandatory separation physicals for all separating service personnel and also utilize the Benefits Delivery at Discharge (BDD) joint separation exam that was developed and agreed to by both agencies.

POST TRAUMATIC STRESS DISORDER (PTSD)
AND TRAUMATIC BRAIN INJURY (TBI)

VA operates a network of more than 190 specialized Post Traumatic Stress Disorder (PTSD) outpatient treatment programs throughout the country. Vet Centers are seeing a rapid increase in their enrollment. Equally important, AMVETS is concerned about the lack of awareness and screening among health care professionals for Traumatic Brain Injury (TBI). PTSD and TBI clinically present the same symptoms and the problem for medical personnel is trying to differentiate between PTSD and TBI. VA's approach to PTSD is to promote early recognition of this condition and the same must be done for TBI. In addition, there is no medical diagnostic code specific to TBI. AMVETS is asking Congress to increase funding for PTSD and TBI,

with an emphasis on developing improved screening techniques and assigning a new medical code specifically for TBI.

VA BURIAL ALLOWANCE

VA reimbursement benefits were first instituted in 1973 and provided $150 in reimbursements for deaths that were not service-related. In 2001 the plot allowance was increased for the first time in more than 28 years, to $300. The non-service-connected burial allowance was last adjusted in 1978 and now also provides $300. AMVETS supports increasing the non-service-connected burial benefit from $300 to $1,270 and increasing the plot allowance from $300 to $745, an amount proportionally equal to the original benefit. In 2001, Congress increased the burial allowance for service-related deaths from $500 to $2,000. Prior to this adjustment, the allowance had been untouched since 1988. AMVETS recommends increasing the service-related burial benefit from $2,000 to $4,100, restoring the value of burial costs to its original proportionate level.

VA CLAIMS BACKLOG

The VA Claims Backlog is now over 600,000 outstanding claims and it continues to grow at a rapid rate. VA's estimates that over 263,000 OEF/OIF veterans will seek VA services and most will want to file a claim. At the end of FY 2006, rating-related compensation claims were pending an average of 127 days, which is 16 days more than at the end of FY 2003. During the same period, the inventory of rating-related claims grew by almost half, in part because of increased filing of claims, including those filed by veterans of the Iraq and Afghanistan conflicts. Meanwhile, appeals resolution remains a lengthy process, taking an average of 657 days in FY 2006. Overall, a lack of quality control is central to this issue and VA must establish a long-term strategy focused on attaining quality and not merely achieving quotas in claims processing. AMVETS supports increased funding for VA to hire more Full Time Equivalents (FTEs) in order to address the backlog. AMVETS also supports the practice putting adjudication officers in VA offices aboard active duty military bases.

If you have questions regarding these priorities, or you need additional information, I can be reached at (614) 431–6990 Again, thank you for holding this hearing and providing AMVETS the opportunity to present its views.

Senator BROWN. Mr. Ondick, thank you. And if you would like to correct the CBOCs part of your testimony and resubmit, that would be fine, if you would like to make those written changes. And I'd like to introduce Mr. Montague. Thank you for joining us from Stokes. He is the CEO of Stokes Medical Center which coordinates most of veterans' care in the state. Thank you for joining us, Mr. Montague.

Congressman Space.

Mr. SPACE. Thanks, Senator Brown. I'd like to thank you, the first three witnesses. Before I introduce the remaining witnesses on this panel, I would ask or remind you to speak as closely to the mic as you can to eliminate feedback. And if you hear that sound, that means that you've surpassed the 7-minute limit, and we'd ask that you begin to wrap-up your testimony.

I'd like to now present Mr. Robert Bertschy, who is a World War II and Korean era Navy veteran, and is also serving as Senior Vice Commander of the Disabled American Veterans for the Department of Ohio.

Mr. Bertschy.

STATEMENT OF ROBERT BERTSCHY, SENIOR VICE COMMANDER, DEPARTMENT OF OHIO, DISABLED AMERICAN VETERANS

Mr. BERTSCHY. Thank you, sir. On behalf of more than 41,000 members of the Disabled American Veterans and its Auxiliary in Ohio, I am honored to appear before you this morning to discuss

the agenda and major concerns of our Nation's wartime disabled veterans and their families. Herman Morton, DAV Department of Ohio Commander, sends his regrets that he could not attend this hearing due to another commitment.

Senator Sherrod Brown and Representative Space, I want to personally congratulate you for hosting this hearing, and wanting to learn more about our veteran issues here in Ohio. The Disabled American Veterans mission is service to veterans.

I am proud to report that our Ohio DAV Transportation Network has 43 DAV vans, with 130 volunteer drivers, transporting thousands of veterans to and from the VA Medical Centers and community-based outpatient clinics. There are five VA Medical Centers, 29 CBOCs in Ohio, VA VISN 10. Louis Stokes Cleveland VA has two VA Medical Centers, and 12 CBOCs serving veterans.

Louis Stokes Cleveland has 18 vans, and 40 drivers; Chillicothe has 15 vans and 40 drivers; Dayton has 3 vans with 10 drivers; Columbus has 4 vans with 11 drivers, and Cincinnati has 2 vans with 10 drivers.

DAV volunteer drivers are saving the VA thousands of dollars. Ohio Veterans Service Commission County Offices has paid drivers that also transport veterans to and from the VA Medical Centers.

Although there have been cases where veterans living in rural areas encounter difficulty in obtaining transportation on a timely basis, this has been more of problem for such veterans getting to Cincinnati VA Medical Center than others. It is not felt that the lack of transportation is a real problem.

We have a lot of veterans coming home from Iraq and Afghanistan. Are we prepared to help them? What good are all these medical centers and clinics, volunteer drivers and vans, if we aren't getting the VA appropriations from Congress on a timely manner? Additional funds for hiring more doctors and nurses at the VA medical centers are needed to improve the delays in providing timely clinic appointments for our veterans. Many veterans will have serious injuries requiring long-term care. Amputations, traumatic brain injuries, vision loss, and mental health issues are only a few healthcare issues facing our veterans, as well as the VA in providing services. Our veterans must not be forgotten for their sacrifices made in time of war. Their sacrifices and service to our great Nation shall not be in vain. We need your commitment that Washington will not forget our veterans. Please make this commitment a top priority for their service.

At the veterans' joint meeting in Washington, DC, in February, we asked the new senators and representatives to support VA mandatory funding. The 2008 Fiscal Year Budget comes close to providing adequate funding. It does not guarantee that VA funds will be available, when needed, since even though it is in the budget, the majority of VA funds are subject to the legislative process throughout the fiscal year, and is subject to the ravages of other funding constraints. Mandatory funding will not cost more tax dollars, and would prompt timely, and proper management of the VA budget, and, thus, provide better, more timely care for our sick, wounded and disabled veterans. At the beginning of each fiscal year, mandatory funding will not force the VA to go into a shutdown fiscal mode until Congress figures it out.

Also, we ask you to repeal the attorney fee provisions, Public Law 109–461.

Ranking Member of the U.S. Senate Committee on Veterans' Affairs, Senator Larry Craig, inserted provision in this bill to remove the bar against attorneys charging veterans a fee for filing a claim. Our DAV Service Officers are very well trained to assist veterans and their families in filing VA claims for benefits they have earned, and we do it for free. It has been this way since the Civil War. As the saying goes, why fix it if isn't broke?

The Disabled American Veterans is a non-partisan veterans service organization, but I personally feel that Senate Majority Leader Harry Reid should stop his negative attitude, and accusations of defeat in Iraq.

At a press conference on Capitol Hill, he claimed that "this war is lost and the surge is not accomplishing anything." He claims that the Iraqi War was a "failure". What kind of message does this send to our soldiers, Marine and Sailors overseas? This is having a negative impact on our troops that are in harm's way.

In effect, statements of this type by our elected leaders gives aid and comfort to our enemies, serving to prolong the conflict, and cause hardship and loss of lives of our brave soldiers.

If you look at all of the cars with signs, "Support Our Troops", on them, and then have our politicians say we are losing the war is shameful. He would have us quit on our troops, even though they haven't quit on us, or their mission in Iraq.

Be assured, DAV will continue supporting our veterans, their families, and VA hospital programs. Again, DAV National Service Officers, professional staff are the very best trained who are representing thousands of veteran filing VA claims for earned benefits, and we do not charge for our services.

The VA must hire more adjudicators to process veterans' claims for benefits they have earned and are not receiving them in a reasonable time, especially for our World War II veterans.

I want to thank you for all that your Veterans' Committees in Washington, DC, have done for our disabled veterans, and for all you will do in the future. Thank you for allowing me to appear before you on behalf of the Disabled American Veterans, Department of Ohio. God Bless all of you, God Bless our American troops in harm's way, and God Bless the USA.

[The prepared statement of Mr. Bertschy follows:]

PREPARED STATEMENT OF ROBERT H. BERTSCHY, VICE COMMANDER, DEPARTMENT OF OHIO, DISABLED AMERICAN VETERANS

On behalf of more than 41,000 members of the Disabled American Veterans (DAV) and its Auxiliary in Ohio, I am honored to appear before you this morning to discuss the agenda and major concerns of our Nation's wartime disabled veterans and their families. Herman Morton, DAV Department of Ohio Commander, sends his regrets that he could not attend this hearing due to another commitment.

Senator Sherrod Brown and Representative Zach Space, I want to personally congratulate you for hosting this hearing and wanting to learn more about our veterans issues here in Ohio.

The Disabled American Veterans mission is service to veterans.

I am proud to report that our Ohio DAV Transportation Network has 43 DAV vans with 130 volunteer drivers transporting thousands of veterans to and from the VA Medical Centers (VAMCs) and Community Based Outpatient Clinics (CBOCs). There are 5 VAMCs, 29 CBOCs in Ohio VA VISN 10. Louis Stokes Cleveland VA has 2 VAMCs, and 12 CBOCs serving veterans.

VAMC	Volunteer drivers	Vans
Louis Stokes Cleveland	40	18
Chillicothe	40	15
Dayton	10	3
Columbus	11	4
Cincinnati	10	2

DAV volunteer drivers are all volunteers saving the VA thousands of dollars. Ohio Veterans Service Commission County Offices has paid drivers that also transport veterans to and from the VAMCs.

Although, there have been cases where veterans living in rural areas encounter difficulty in obtaining transportation on a timely basis. This has been more of a problem for such veterans getting to Cincinnati VAMC than others. It is not felt that lack of transportation is the REAL problem!!

We have a lot of veterans coming home from Iraq and Afghanistan. Are we prepared to help them? What good are all of these medical centers and clinics, volunteer drivers and vans if we aren't getting the VA appropriations from Congress on a timely manner? Additional funds for hiring more doctors and nurses at the VA medical facilities are needed to improve the delays in providing timely clinic appointments for our veterans. Many veterans will have serious injuries requiring long-term care. Amputations, traumatic brain injuries, vision loss and mental health issues are only a few healthcare issues facing our veterans as well as the VA in providing services. Our veterans must not be forgotten for the sacrifices made in time of war. Their sacrifices and service to our great Nation shall not be in vain. We need your commitment that Washington will not forget our veterans. *Please make this commitment, a top priority, for their service.*

At the Veterans' joint meeting in Washington, DC, in February, we asked the new senators and representatives to support "VA mandatory funding". The 2008 Fiscal Year Budget comes close to providing adequate funding. It does not guarantee that VA funds will be available when needed since, even though it is in the budget, the majority of VA funds are subject to the legislative process throughout the fiscal year and is subject to the ravages of other funding constraints. "Mandatory Funding" will not cost more tax dollars and would prompt, timely and proper management of the VA budget and thus provide better, more timely care for our sick, wounded and disabled veterans. At the beginning of each fiscal year Mandatory funding will not force the VA to go into a shut-down fiscal mode until Congress figures it out.

Also, we ask you to repeal the attorney fee provisions, Public Law 109–461. Ranking member of the U.S. Senate Committee on Veteran' Affairs, Senator Larry Craig, inserted provisions in this bill to remove the bar against attorneys charging veterans a fee for filing a claim. Our DAV Service Officers are very well trained to assist veterans and their families in filing VA claims for benefits they have earned and we do it for free. It has been this way since the Civil War. Why fix it if it isn't broke?

The Disabled American Veterans is a nonpartisan veterans service organization, but I personally feel that Senate Majority Leader Harry Reid should stop his negative attitude and accusations of defeat in Iraq. At a press conference on Capitol Hill, he claimed that "this war is lost and the surge is not accomplishing anything." He claims that the Iraqi War was a "failure." What kind of message does this send to our soldiers, marines and sailors overseas? This is having a negative impact on our troops that are in harm's way. In effect, statements of this type by our elected leaders gives "aid and comfort" to our enemies, serving to prolong the conflict and cause hardship and loss of lives of our brave soldiers.

If you look at all of the cars with signs, "Support Our Troops," on them and then have our politicians say we are losing the war is shameful. He would have us quit on our troops, even though they haven't quit on us or their mission in Iraq.

Be assured, DAV will continue supporting our veterans, their families and VA hospital programs. Again, DAV National Service Officers professional staff are the very best trained who are representing thousands of veterans filing VA claims for earned benefits and we do not charge for our services.

The VA must hire more adjudicators to process veterans' claims for benefits they have earned and are not receiving them in a reasonable time. Especially for our WW II veterans.

Thank you for all that your veterans' committees in Washington, DC, have done for our disabled veterans and for all you will do in the future. Thank you for allow-

ing me to appear before you on behalf of the Disabled American Veterans, Department of Ohio. God Bless all of you, God Bless our American troops in harm's way and God Bless the USA.

Mr. SPACE. Thank you, Mr. Bertschy. I'd like to now introduce Mr. Tom Burke, President of the Vietnam Veterans of America, Buckeye State Council. I'm privileged to introduce Mr. Burke. Not only are you a panelist today, but you are also a constituent. I understand that you live just a few blocks from here, where we sit this morning.

Good morning, and thank you for your anticipated testimony.

STATEMENT OF TOM BURKE, PRESIDENT, BUCKEYE STATE COUNCIL, VIETNAM VETERANS OF AMERICA

Mr. BURKE. Thank you. On behalf of the members and families of the Vietnam Veterans of America, Buckeye State Council, we bid you welcome. To Congressman Space we say, "Welcome Home." We'd like to thank you all for what it is that you do for us. We wish to express our deep appreciation to you all for taking time out of your schedules to come to New Philadelphia for the purpose of hearing veterans concerns firsthand.

It is my great privilege to speak to you today to present the thoughts and comments gathered from Vietnam Veterans of Ohio on issues that impact members of small town America. Funding you approve in the interest of Veterans Across America, certainly make us better than we were many years. The recent funding increase of $3.6 billion for the veterans Healthcare is certainly important and necessary. It goes without saying that sufficient funding for veterans must be met, or nothing happens.

In preparing for today's hearing, I have spoken to many veterans. Not surprisingly, the number one issue that comes up across the board is their concern for healthcare. More than half of the veterans who avail themselves of VA facilities here in Ohio are without medical insurance of any kind. VA hospital facilities located in the Cleveland, Cincinnati, Chillicothe, and Dayton, access to VA facilities in urban areas is practically unlimited because veterans can go to VA emergency wards for treatment of ailments. However, this is not the case for rural veterans.

We have the VA clinics in smaller cities on this side of the state. The clinic here in New Philadelphia is said to be the fastest growing clinic in the state. This is due to the ever-increasing medical needs by not only older veterans, but by the new crop of veterans currently returning from the war zone. It is not secret that the media sources report that the VA is at the breaking point.

These reports concern many veterans because they fear the VA will attempt to scale back their care because of limited funding, or because of the influx of current Iraq and Afghanistan veterans returning from the combat zone. VA clinic facilities are situated in Canton, Youngstown, Akron, each providing different specialties for the veterans. The medical help that these facilities provide through dedicated doctors, nurses, and staff is absolutely critical to the healthcare of veterans in non-urban areas.

An issue that many veterans grimace at in Oho is this; veterans whose incomes are at the poverty level have little choice concerning healthcare. However, they are fortunate that the system does pro-

vide care for them. veterans turn to the VA for medical assistance for a variety of reasons. Reasons cited by veterans include those whose income or lack of service-related disability forces them into Category 7 and 8, but a majority of these veterans have no medical insurance. Others have no employer sponsored medical insurance, and still others are deemed uninsurable by the private sector. Most of these veterans can ill afford private insurance under any circumstances. Many veterans in Ohio and elsewhere are denied care by the current Administration as a matter of policy. Fortunately, some got in during the open enrollment period before the Administration closed the door. Estimates of these veterans now sitting out there are roughly 500,000 since 2003. Gentlemen, this closed door policy must be rescinded. It is time to reopen the VA health care system to Priority 8 veterans, who were restricted from enrolling since January of 2003.

The closest VA hospital for us here in this area is Cleveland. To get to the Cleveland Wade Park VA hospital is approximately 200 miles round trip, or more, at best, depending on the veteran's location of residence. The VA current mileage scale allows veterans going to any facility 11 cents per mile. Gasoline currently is better than $3 a gallon. First of all, this computation does not compute. A majority of Priority 6, 7, and none of the Priority 8 veterans who are currently in the system get any mileage at all. The VA simply says "you make too much money". Yet, others of higher priority, regardless of their income, still receive mileage. This does not make sense to most veterans, nor do they believe it is fair.

I have a check here from one veteran that lives in Carolton that was going to the VA facility at Canton. They held back $18 as a hold-back, and he went to the—if you don't go to the facility more than three times a month, you don't get the full pay. Well, the government issued him a check for mileage for 16 cents. It seems a little incredible that a veteran going to a VA facility gets a mileage check for 16 cents. The paper and the administration fees would cost more than that to put it out. It doesn't make any sense to us.

I've been in many conversations concerning veterans not only here in Ohio, but about everywhere I go concerning the backlog of VA claim adjudication. No one seems to know what the actual number is, four, five, six hundred thousand, but one thing is sure, it's a big number, and must be dealt with as quickly as possible. Many veterans are concerned about the time that it takes to get a rating at all after there claims have been submitted. I am advised by our VSO people that waits of one to two years are not out of the question for initial claims. If one appeals a decision, add another two to five years. Gentlemen, this is simply not acceptable. With the new crop of veterans returning from our current war zone, there is a high concern among older veterans that their claims are getting lost in the bureaucratic log jam. We understand that new adjudicators are coming, but we need to be assured that the new kids on the block are properly trained, and held accountable for their work.

Gentlemen, the balance of my comments are submitted for the record. That concludes my comments. Thank you.

[The prepared statement of Mr. Burke follows:]

PREPARED STATEMENT OF THOMAS R. BURKE, PRESIDENT, BUCKEYE STATE COUNCIL, VIETNAM VETERANS OF AMERICA

To the distinguished Members of the House/Senate Veterans Affairs Committee who have come to the fair City of New Philadelphia, Ohio this morning. On behalf of the members and families of Vietnam Veterans of America, Buckeye State Council we bid you welcome. To Congressman Space we say "Welcome Home." To all we thank you for what it is that you do for us. We wish to express our deep appreciation to you all for taking the time out of your schedules to come to New Philadelphia for the purpose of hearing veterans concerns firsthand.

It is my great privilege to speak to you today to present the thoughts and comments gathered from Vietnam Veterans of Ohio on issues that impact our members of small town America. Rather than providing you with a laundry list, I will attempt this morning is to bring to you only those issues that arose in conversation time and again. We are aware that difficult decisions must be made by this Committee for the benefit of all veterans. Funding you approve in the interest of veterans across America, certainly make us better today than we were many years ago. The recent funding increase of $3.6 billion for veterans health care is truly important and necessary. It goes without saying that sufficient funding for veterans must be met or nothing happens. We also know that many issues remain.

FUNDING VETERANS HEALTH CARE AND RURAL CARE

In preparing for today's hearing, I have spoken to many veterans. Not surprisingly the number one issue that comes up across the board is their concern for health care. Ohio currently has one million plus veterans. Nearly 8,000 of those veterans call Tuscarawas county their home. Funding for veteran issues concerning research, toxic exposure, the effects of Traumatic Brain Injury, Post traumatic stress disorder, prosthetic limbs, homeless veterans, our POW/MIA's issues, improvement of facilities that treat all our veterans and combat wounded. All these and more must be funded by money distributed from Congress from non-discretionary funding sources. This is the only way that veterans can be assured that their issues will not be lost.

More than half of the veterans who avail themselves of VA facilities here in Ohio are without medical insurance of any kind. VA hospital facilities are located in Cleveland, Cincinnati, Chillicothe, and Dayton. Access to VA hospital facilities in urban areas is almost unlimited because veterans can go to the VA emergency wards for treatment of ailments. However, that is not the case for rural veterans. We have VA Clinics in smaller cities on this side of the state. The clinic here in New Philadelphia is said to be the fastest growing clinic in the state. This is due to the ever increasing medical needs by not only older veterans, but by the new crop of veterans currently returning from the war zone. It is no secret that media sources report that the VA is at the breaking point.

These reports concern many veterans because they fear VA will attempt to scale back their care because of limited funding or the influx of current Iraq and Afghanistan veterans returning from the combat zone. Additional VA clinic facilities are situated in Canton, Youngstown and Akron each providing different specialties for veterans. The medical help that these facilities provide through dedicated doctors, nurses and staff is absolutely critical to the health care of veterans in non-urban areas.

For the most part veterans rate services provided by clinics and hospitals as good to excellent. However, we find that medical clinic access seems to vary from clinic to clinic. A veteran will usually get in to see a doctor at a clinic about once very 6 months as part of a routine wellness physical if he or she is in the system. Should you be a new patient seeking treatment you may wait a longer period of time. Many of the veterans stated that if they become ill between their normal visits to the clinic, that they are unable to see a VA doctor if they request appointments. All believe that this is a result of VA limiting staffing policies. At a time when VA should be gearing up personnel, i.e., current veterans returning, putting more pressure on the system to perform, they seem to be going the other way. Veterans who seek help at the VA facilities that are rated 100 percent are admitted within a couple of days. Others who are less than a 100 percent may not get in at all if they are sick. The same also holds true for dental care as well. Some veterans have come to believe their access to VA facilities may be based on their Priority status or lack thereof. Perhaps a facility that has a larger staff may afford that clinic to accommodate the veteran needs. Veterans note that there does not seem to be any uniformity between facilities.

An issue that many veterans grimace at in Ohio is this. Veterans whose incomes are at the poverty level have little choices, concerning health care; however, they

are fortunate that the system does provide care for them. Veterans turn to the VA for medical assistance for a variety of reasons. Reasons cited by veterans include those whose income or lack of service related disability, forces them into Priority 7 and 8, but a majority of these veterans have no medical insurance. Others have no employer sponsored medical insurance and still others are deemed uninsurable by the private sector. Most of these veterans can ill afford private insurance under any circumstances. Many veterans in Ohio and elsewhere are denied health care by the current Administration as a matter of policy. Fortunately some got in during the open enrollment period before the Administration closed the door. Estimates of these veterans now sitting out there are roughly 500,000 since 2003. Gentlemen, this closed door policy must be rescinded. It is time to reopen the VA health care system for Priority 8 veterans, who were restricted from enrolling in January 2003.

Additionally, insufficient funding by Congress to take care of all who were promised health care as a condition of their service, still others who are forced to private health care and cannot afford prescription medications they need. We add a big thank you for VA prescription drug service, in some cases a life saving service. Ironically, Congress always seems to be able to find funds to wage war, which is necessary to support current combat troops. We certainly need to support our troops. However, once home, the Congress must find the necessary funds to treat and care for our veterans.

REVAMPING

A revamping of the funding for veterans health care is an overwhelming issue that must be dealt with. H.R. 1382 is a start, Mandatory Funding for Veterans Health Care 2008. Gentlemen the current discretionary funding method for VA medical care simply does not work. VVA has long maintained that accountability must be built into any system of funding for the VA. Simply throwing cash at a problem will probably not work either. We must find long term solutions. Veterans in Ohio are certainly willing if not eager to work with whoever it takes, to find a way to ensure the VA has the funding to meet its mandate to "care for them who have borne the battle." If we cannot find a way to maintain and improve care as time proceeds, we may find all veterans without benefits. This is a fate that we cannot let happen. Perhaps a bipartisan group should be formed whether in our state or on a national level to study the issues, options and hopefully solutions.

MILEAGE ISSUE

The closest VA hospital for us is Cleveland. To get to Cleveland Wade Park VA hospital is a 200-mile roundtrip or more at best depending on the veterans' location of residence. The VA current mileage scale allows veterans going to any facility eleven (11) cents per mile. Gasoline currently is better than three dollars a gallon. First of all this computation does not compute. A majority of Priority six (6) seven (7) and none of the Priority eight (8) veterans who are currently in the system get any mileage at all. The VA says "you make too much money". Say what? Yet others of higher priority regardless of their income still receive mileage. This does not make sense to most veterans, nor do they believe it is fair.

OUTREACH

In the State of Ohio, we have found that many veterans who have served honorably simply are unaware of benefits and or services that they are entitled too. Many were not told of available benefits or services when they left their branch of service and never thought another thing about it. Outreach should be an ongoing effort to all veterans but especially in country veterans so they become aware that their likelihood of contracting a dreadful disease is much higher than the general public.

ADJUDICATION OF CLAIM BACKLOG

I have been involved in many conversations concerning veterans not only here in Ohio but about everywhere I go concerning the current backlog of VA claim adjudication. No one seems to know what the actual number is, four, five, six, and hundred thousand. But one thing is for sure. It's a big number and must be dealt with as quickly as possible. Many veterans are concerned about the length of time that is takes to get a rating at all after claims have been submitted. I am advised by our VSO people that waits of 1 to 2 years are not out of the question for an initial claim. If one appeals a decision add another 2 to 5 years. This is simply not acceptable. With the new crop of veterans returning from our current war zone, there is high concern among older veterans that their claims are getting lost in the bureaucratic log jam. We understand that new adjudicators are coming, but we need to be

assured that the new kids on the block are properly trained and held accountable for their work.

EMPLOYMENT, TRAINING

It seems that the so called "veterans preference" which we all know is on the books nationally certainly does not appear close to being enforced. Veterans both National Guard and Reservists returning to Ohio have faced no job or a job that has been reengineered, in effect again losing their career position. To veterans who return with less of a body than they started with they certainly deserve to be given chance to maintain employment if they are physically able to do so for their own well being. To assist veterans who are unemployed or underemployed with new or additional training seems vital to us. Veterans who lose their jobs should have the opportunity to get a re-education and work skill upgrades. S. 22, S. 644, and H.R. 1102 would establish educational assistance for various veterans and Reserve elements. Ohio Vietnam Veterans feel these initiatives should be supported. With respect to our older veteran population national standards now cite retirement age increasing to a minimum age of 66. Federal, state, and private employers need to start rethinking their priorities toward older veterans and workers in general when it comes to keeping them in the workforce. With the increased standards, veterans reaching fifty years old or older are being shelved for younger less experienced people because their income combined with group benefits provided has reached a level that employers increasingly are not willing to pay. Federal agencies that provide job services to veterans should note this reality shift and make priority changes so veterans cannot only maintain their jobs, but find new ones if necessary.

POW/MIA

The Vietnam Veterans of Ohio, along with The POW/MIA Families, on this issue have the strongest possible feelings. Prisoners of War and those missing in action must be accounted for and not left behind. We urge the Congress pass a resolution. Such resolution should be presented to the government of Vietnam to give up relevant wartime documents, so the remains of war dead may be brought home and those listed as MIA should be accounted for.

I speak from personal experience when I tell you that having a brother KIA in Korea was bad enough for my family. I cannot imagine what it would have been like especially for my parents if they had not known the fate of their fallen son.

Distinguished Members of the House and Senate Veterans' Affairs Committee that concludes my testimony on behalf of the Vietnam Veterans of America, Buckeye State Council.

Mr. SPACE. Thank you, Mr. Burke.

And I'd like to introduce our last witness on the first panel, Mr. Donald Lanthorn, a Vietnam veteran, and the Department Service Director from The American Legion, Department of Ohio.

Thank you, Mr. Lanthorn, for being here today, and presenting your testimony.

STATEMENT OF DONALD LANTHORN, SERVICE DIRECTOR, DEPARTMENT OF OHIO, THE AMERICAN LEGION

Mr. LANTHORN. Senator Brown, Representative Space, it's my pleasure to be here today. Thank you for this opportunity to provide our organization's views on VA healthcare, its accessibility, and needs to be considered by Congress from the point of view of Ohio veterans and members of our organization.

My first experience with VA healthcare was 30 years ago. At that time, VA Medical Centers had long lines, inadequate waiting areas, and few facilities. I was appalled by patients having to sit in hallways, on the floor, waiting for their opportunity to see a doctor, after having traveled perhaps 100 miles within Ohio to be seen.

However, even in those trying times, medical care was comparable to the private sector, but few with the alternatives available through health care insurance would select VA as the health care provider of choice. Even veterans with service-connected

conditions would often opt for private sector treatment for the convenience.

The 1980s saw some improvement in access, as VA Medical Centers in Ohio expanded the ambulatory care clinics, opened a few outpatient clinics, and moved toward outpatient, rather than inpatient care, as the preferred method of treatment.

Beginning in 1994, Dr. Kenneth Kizer, VA Undersecretary for Health, began revamping the system to his vision of accessibility, quality, and safety. He is arguably credited with setting in motion the plan that closed under-used facilities, established hundreds of new access points with clinics, and created a business model of efficiency utilizing available technology to digitize records, to common sense in informing patients about their medications.

As word spread of the quality of VA healthcare, veterans left their private plans and sought VA healthcare in droves. Without funding to handle the patient influx, VA was forced in 2003 to again restrict access, as waiting lists grew, so now only service-connected and low income veterans were eligible to enroll, slamming the door to hundreds of thousands of veterans planning on using VA healthcare in retirement, or sooner.

A vital part of the VA transformation was the accessibility created for veterans by establishing community-based outpatient Clinics. They brought healthcare closer to where veterans live, and provide mental health services, often otherwise not available in rural communities.

Ohio has CBOCs in Athens, Cambridge, Lancaster, Marietta, and Portsmouth affiliated with Chillicothe VA Medical Center, and Clermont County near Cincinnati VA Medical Center. Dayton VAMC has CBOCs in Lima, Middletown, and Springfield. Columbus VA Outpatient Clinic serves Grove City, Marion, Newark, and Zanesville with CBOCs. Cleveland VAMC, the most aggressive of all Ohio Medical Centers in establishing VA points of access, has CBOCs in Akron, Canton, East Liverpool, Lorain, Mansfield, McCafferty in downtown, New Philadelphia, Painesville, Ravenna, Sandusky, Warren, and Youngstown.

Additionally, Ohio medical facilities have established CBOCs in Indiana and Kentucky, which serve Ohio veterans, as does the Toledo Clinic, a satellite of Ann Arbor VAMC, and other Ohio CBOCs in Ashtabula and St. Clairsville, established by VA facilities in bordering states.

The Ohio American Legion strongly supports the recommendation of the Capital Asset Realignment for Enhanced Services (CARES), recommendations for more CBOCs, and expanded services in those now operating, especially those in rural areas. However, limited VA discretionary funding has slowed the number of clinics authorized each year. Field stations partially meet access needs, but are not sufficient in availability or services.

The current war and its estimated toll on veterans' mental health make these services vital in CBOCs for our returning troops ease of access. We urge sufficient VA funding to ensure adequate staffing.

Traumatic Brain Injury veterans similarly find few community resources in rural areas for TBI-related problems, and many cite transportation as a major obstacle. We have addressed the trans-

portation issue in Ohio with state legislation requiring County Veterans Service Commissions to provide it. Now VA must provide the services with the patient at the doorstep.

Vet Centers are another resources VA provides, which is not readily available in rural communities. Veterans should not be penalized or denied quality healthcare because of where they choose to live. We urge Congress and VA to improve access to quality primary care, specialty healthcare, and mental health services in rural areas.

As important as access as may be, just as critical is timeliness of services. VA has established its own standards for access to primary care of 30 days. That is unacceptable to most Americans, and especially does not meet the obligations of VA to our veterans.

The Ohio American Legion does not point fingers at problems without offering a means of resolution. We disagree with the VA decision to deny access to any eligible veteran. Many of these veterans have third-party insurance that could reimburse VA, or are Medicare-eligible, yet little has been done to improve third-party reimbursements for private insurers, and nothing to allow VA to receive reimbursement from the Nation's largest healthcare insurer, the Centers for Medicare and Medicaid Services, as both the Indian Health Services and Department of Defense are authorized to bill, collect, and receive.

Full funding for VA healthcare, full eligibility for all veterans, and Medicare reimbursement to VA is the first step needed to assure quality healthcare to rural Ohio veterans.

Thank you, Mr. Chairman, for providing the Ohio American Legion this opportunity to address the issues of VA healthcare in Ohio, and the disparities that exist in access to quality healthcare in rural areas.

[The prepared statement of Mr. Lanthorn follows:]

PREPARED STATEMENT OF DONALD R. LANTHORN, SERVICE DIRECTOR, DEPARTMENT OF OHIO, THE AMERICAN LEGION

Mr. Chairman, Members of the Committee. My name is Donald R. Lanthorn. I am the Service Director and Legislative Agent for The Ohio American Legion.

It is my pleasure to be here today. Thank you for this opportunity to provide our organization's views on VA health care, its accessibility and needs to be considered by Congress from the point of view of Ohio veterans and members of our organization.

My first experience with VA health care was thirty years ago. At that time VA Medical Centers had long lines, inadequate waiting areas and few facilities. I was appalled by patients having to sit in hallways, on the floor, waiting for their opportunity to see a doctor, after having traveled perhaps one hundred miles within Ohio to be seen.

However, even in those trying times, medical care was comparable to the private sector, but few with the alternatives available through health care insurance would select VA as the health care provider of choice. Even veterans with service-connected conditions would often opt for private sector treatment for the convenience.

The 1980s saw some improvement in access, as VA Medical Centers in Ohio expanded the ambulatory care clinics, opened a few Outpatient Clinics and moved toward outpatient, rather than inpatient care, as the preferred method of treatment.

Beginning in 1994 Dr. Kenneth Kizer, VA Undersecretary for Health, began revamping the system to his vision of accessibility, quality, and safety. He is arguably credited with setting in motion the plan that closed underused facilities, established hundreds of new access points with clinics, and created a business model of efficiency utilizing available technology to digitize records, to common sense in informing patients about their medications.

As word spread of the quality of VA health care, veterans left their private plans and sought VA health care in droves. Without funding to handle the patient influx, VA was forced in 2003 to again restrict access, as waiting lists grew, so now only service connected and low income veterans were eligible to enroll, slamming the door to hundreds of thousands of veterans planning on using VA health care in retirement or sooner.

A vital part of the VA transformation was the accessibility created for veterans by establishing Community Based Outpatient Clinics (CBOCs). They brought health care closer to where veterans live and provide mental health services often otherwise not available in rural communities.

Ohio has CBOCs in Athens, Cambridge, Lancaster, Marietta and Portsmouth affiliated with Chillicothe VAMC, and Clermont County near Cincinnati VAMC. Dayton VAMC has CBOCs in Lima, Middletown, and Springfield. Columbus VA Outpatient Clinic serves Grove City, Marion, Newark, and Zanesville with CBOCs. Cleveland VAMC, the most aggressive of all Ohio Medical Centers in establishing VA points of access, has CBOCs in Akron, Canton, East Liverpool, Lorain, Mansfield, McCafferty in downtown, New Philadelphia, Painesville, Ravenna, Sandusky, Warren and Youngstown.

Additionally, Ohio medical facilities have established CBOCs in Indiana and Kentucky, which serve Ohio veterans, as does the Toledo Clinic, a satellite of Ann Arbor VAMC, and other Ohio CBOCs in Ashtabula and St. Clairsville, established by VA facilities in bordering states.

The Ohio American Legion strongly supports the recommendation of the Capital Asset Realignment for Enhanced Services (CARES) recommendations for more CBOCs, and expanded services in those now operating, especially those in rural areas. However, limited VA discretionary funding has slowed the number of clinics authorized each year. Field Stations partially meet access needs, but are not sufficient in availability or services.

The current war and its estimated toll on veterans' mental health make these services vital in CBOCs for our returning troops ease of access. We urge sufficient VA funding to ensure adequate staffing.

Traumatic Brain Injury (TBI) veterans similarly find few community resources in rural areas for TBI related problems, and many cite transportation as a major obstacle. We have addressed the transportation issue in Ohio with state legislation requiring County Veterans Service Commissions to provide it. Now VA must provide the services with the patient at the doorstep.

Vet Centers are another resource VA provides, which is not readily available in rural communities. Veterans should not be penalized or denied quality health care because of where they choose to live. We urge Congress and VA to improve access to quality primary care, specialty health care and mental health services in rural areas.

As important as "access" may be, just as critical is "timeliness" of services. VA has established its own standards for access to primary care of 30 days. That is unacceptable to most Americans, and especially does not meet the obligation of VA to our veterans.

The Ohio American Legion does not point fingers at problems without offering a means of resolution. We disagree with the VA decision to deny access to any eligible veteran. Many of these veterans have third-party insurance that could reimburse VA, or are Medicare eligible, yet little has been done to improve third-party reimbursements from private insurers and nothing to allow VA to receive reimbursement from the nation's largest health care insurer, the Centers for Medicare and Medicaid Services (CMS), as both the Indian Health Services (IHS) and Department of Defense (DoD) are authorized to bill, collect, and receive.

Full funding for VA health care, full eligibility for all veterans, and Medicare reimbursement to VA is the first step needed to assure quality health care to rural Ohio veterans.

Thank you, Mr. Chairman, for providing The Ohio American Legion this opportunity to address the issues of VA health care in Ohio and the disparities that exist in access to quality health care in rural areas.

Senator BROWN. Thank you, Mr. Lanthorn.

I will begin the questioning, and feel free, any of you, to jump in if the question is directed at one of you. Feel free to also add your thoughts to the answers.

Mr. Anderson, Mr. Moore talked about contracting out. I'd like to pursue that a bit. Mr. Moore, you said that contracted care takes money out of the system, and potentially dilutes quality of care.

Mr. Anderson, you said that you fear that the VA will become the insurer of care, not the provider of care. That results in a diminution of the quality of care. Would each of you expand on that a bit? Mr. Moore first, then Mr. Anderson.

Mr. MOORE. Well, again, we're very concerned with that aspect. When we're looking for our dollars, and we're fighting for our dollars continually, that if you—in the past what I saw is simply that when we've contracted in the past to private entities, the veteran always end up, seems to me, to suffer. The billing system gets messed up. He doesn't get his care on time, or it doesn't get paid on time. He gets threatening letters continually that that private sector hospital is going to turn it over to a collection agency because it hasn't been paid by the VA; and, therefore, he's responsible for it. That's one of the issues I see that bothers me with contracting care out. I've seen that happen several times in the Columbus area when they contracted out for some of the—University Hospital, a veteran came in with all kinds of problems, threats if the bills weren't paid, and everybody is arguing back and forth between them and fee-basis, who's responsible for that. Well, they are, they aren't. In the end, the poor veteran is sitting there suffering, and he's being threatened by ruining his credit and everything else. That's one fear I have about contracting out. Unless, again, Congress and the VA itself, and any of these contracted out medicals really need to look at it and keep auditing that system, keep a very strong hand on it, making sure that it's done properly.

Senator BROWN. Have you seen an increase in the number of veterans who serve with those problems, with the problems of the mix of privatized or contracted out care?

Mr. MOORE. Fortunately, most of them in Ohio, we have a very strong VA healthcare system in there, thanks to Director Montague and others that pushed that. When you look at Ohio compared to its sister states that in that Appalachia area that we're talking about, West Virginia and Kentucky, you're looking at roughly 20 probably rural CBOCs and whatnot within Ohio, but in West Virginia you're looking at six or seven CBOCs, in Kentucy about the same. And it's very difficult for those individuals to get in and get timely healthcare appointments. I'm worried that, I think CBOCs and those people who reach out to the veterans who make those house calls on those that are house-bound, and/or have mental health conditions that make it difficult for them to come in, we are very short on those types of people. We need more of them. They do an excellent job. They're very committed, but I think we're at the point where we're starting to overwork them. Mental health individuals have to make assessments of some cases in the field, supposed to be about an hour or less than that to try to make some kind of assessment. I would like to see more of that expansion of technology out in the field for those rural people, such as not only the Telebuddy, but they have tele-video where the mental health individual actually sees that individual on a screen and can make assessments, and they can have somewhat of a consultation right there at their home.

Senator BROWN. Thank you. Mr. Anderson, about the diminution of quality of care. Pull the microphone a little closer.

Mr. ANDERSON. When you asked me that question, Mr. Chairman, I looked at myself, and I think I've received some of the best care in the world from the VA. I am a product of that service. I'm specialized service intern of spinal cord injury. I've been receiving service 27 years, and I've gotten some of the best spinal cord injury service around. I've received three surgeries there at the VA Medical Center, and I'm going in for a third one in another month for Harrington rods, I've been experiencing some Harrington rod problems, and the service I received from the VA has been excellent. And as specialized service, only through the VA have I been able to get that quality care of services. And the veterans that I've worked with and serve with, only through the VA have we been able to get that kind of service. So we have received topnotch service, and nowhere have we received such quality care.

Senator BROWN. Mr. Ondick and Mr. Lanthorn, you both talked about 700 CBOCs around the country, 150 cares recommended. Do you specifically recommend expansion? We just announced this week—well, I talked to the Secretary of the VA this week about the Hamilton and Parma new expanded CBOCs. Do you specifically recommend more in Ohio? And if so, does that potentially take money away from other things that the VA is doing? What is your thought about additional CBOCs in Ohio, and even specifically where, if you are recommending that? Your view, and I'd like to ask both of you, but either/or.

Mr. Ondick.

Mr. ONDICK. I have covered in my testimony the list of the facilities that there are in Ohio. There is a significant need for a couple of CBOCs in northwestern Ohio, which is not in VISN 10, but it is in VISN 11 out of Michigan, and Indiana fall into that VISN. Most significantly, that's where our needs need to be addressed. However, we could use a couple of CBOCs in——

Senator BROWN. There is one in Lima now. Correct?

Mr. ONDICK. Yes. Yes, there is.

Senator BROWN. Nowhere between Lima and Toledo?

Mr. ONDICK. Actually, Finley and Defiance would probably be two good locations, or Finley and Bryan, not knowing where there might be one in Michigan.

Senator BROWN. But now there's—outside of Toledo, there's Lima, there's Lorain, east of Toledo, nothing in Bowling Green, nothing in anywhere else other than Lima at this point?

Mr. ONDICK. And Toledo, yes.

Senator BROWN. And Toledo, yes.

Mr. LANTHORN. If Mr. Montague would just hold up the map of Ohio right here, you can see the locations of all the CBOCs, and where the need is.

Senator BROWN. That would be out of the Michigan Center, though, correct?

Mr. ONDICK. Marion. In southeastern Ohio, we are dependent upon CBOCs in Huntington.

Senator BROWN. They're in East Liverpool, they're here, they're Athens, Chillicothe.

Mr. ONDICK. But we are dependent upon CBOCs that are located in St. Clairsville, and then, of course, the VA Center in Huntington to service Ohio veterans, as well.

Senator BROWN. So there's one in Marion. Correct?

Mr. ONDICK. Yes.

Senator BROWN. So Marion and Lima, and Mansfield.

Mr. LANTHORN. You could see the areas that need coverage, that northwest corner. The areas down in Cincinnati, Dayton are covered quite well. There are a few small pockets, and, again from my conversation with Mr. Montague earlier, some of the small pockets along the river, and up along the eastern part of the state are covered by—correct me if I'm wrong, Mr. Montague, but they're covered by CBOCs in other states?

Mr. SPACE. Mr. Lanthorn, while we're on the subject of CBOCs, my understanding is there are five of them in Ohio's 18th Congressional District. That would include one here in New Philadelphia, which I have been told is one of the fastest growing CBOCs in the state, community-based outpatient clinics. In addition, we've got one in St. Clairsville, Cambridge, Zanesville, and Newark. Is that correct?

Mr. LANTHORN. Yes, sir.

Mr. SPACE. Those are the five serving——

Mr. ONDICK. The one in St. Clairsville is not part of VISN 10. That's one we're depending on another VISN.

Mr. SPACE. Right. Those are the five. And the principle behind the CBOC concept is, it's kind of—I've heard the analogy "hub and spoke," with the hubs being the medical centers, like the one we have in Chillicothe, or the one we have in Cleveland; with the spokes being the various CBOCs situated strategically around the state, try to serve those veterans who are not within a short drive to those medical centers. I mean, the concept is a good one, and certainly, we are encouraged by the recent announcement that there are going to be more CBOCs constructed, but the fact of the matter is that some of the CBOCs, all of them, actually, have some serious limitations when dealing with special needs. And I think it was Mr. Ondick that used the example of someone who has to travel 80 miles for radiation therapy, and then travel 80 miles back home. Forget about the fact that the insult of 11 cents per mile, the mere travel and distance, and inconvenience occasioned by that travel is, in and of itself, a significant problem that affects almost exclusively rural veterans.

Aside from making that statement, I wanted to ask you whether—and this applies to anyone on the panel—if you've got some ideas, some creative thoughts on how we can expand access to specialized care in rural America, rural Ohio, in particular, over and above what's presently being offered by the CBOC hub and spoke system.

Mr. ONDICK. Mr. Chairman, it would certainly behoove the VA to, as they provide services in the CBOCs, to provide some specialty services at certain CBOCs so that like Women's healthcare services be available, if not within the 30-mile radius at every CBOC, perhaps overlay those maps with 50 or 60-mile circles that would assure that those specialty services would be available within a certain time and transportation frame for all veterans in the state. This is something that could be done, I'm sure.

Mr. SPACE. Anyone else on the panel have suggestions on how we could enhance specialized care for rural veterans?

Mr. BURKE. Congressman, I know that some of my guys that have commented about the clinic here in New Philadelphia, it is said to be one of the fastest growing in the state. That is because there have been a lot of participation by the veterans in this area. I'm told that the clinic here will soon have eye care, and foot care, podiatry, and the veterans that I've talked to have commented that this is really going to be of a help to them. The more expanded care that can be provided in the small town clinics is certainly going to diminish the time that the veteran has to travel to the major hospital for whatever purpose he has to go there for. So I suggest that the expansion of services at the local clinics would certainly do much to help the veterans in the area.

Senator BROWN. Perhaps Mr. Ondick could answer this. Are there five VA medical centers in the State of Ohio? How many are there in the State of Ohio?

Mr. ONDICK. We have Chillicothe, Cincinnati, Dayton, Cleveland.

Senator BROWN. It seems to me that every region of Ohio is served by a medical center, with the exception of the southeastern area of Ohio.

Mr. BERTSCHY. You've got the—one of the problems is Harrison County. I think it's Harrison County, and one other county, I think it's Jefferson County, that have to go to Pittsburgh, and there is no CBOC. Steubenville has a CBOC, or close-by, but if you look at the ones close to the Ohio River, talking about Morton's Ferry and them areas in there, they have to go to Pittsburgh. That's the only place they can go. There is no CBOC within a 30-mile radius for them. I think if they could expand the old type, what we had, the fee-basis or the fee-basis where they could go to their local hospitals to get this care would help an awful lot.

Senator BROWN. Excuse me. There's a CBOC in East Liverpool, and St. Clairsville. Right?

Mr. BERTSCHY. Right. There is——

Senator BROWN. Where?

Mr. ONDICK. St. Clairsville, is it open yet?

Mr. BERTSCHY. St. Clairsville is open.

Mr. ONDICK. I was thinking it wasn't open.

Senator BROWN. So where are they not getting service? Steubenville doesn't have one, but it's served by——

Mr. BERTSCHY. Steubenville has to go to East Liverpool.

Senator BROWN. East Liverpool, or south of there, Mango Junction maybe goes to St. Clairsville. I don't know, but where do they have to go, to Pittsburgh?

Mr. BERTSCHY. Most of them are going—anyone I talked to, I don't know in Jefferson County, in Steubenville, that most of them will go to Pittsburgh.

Senator BROWN. Rather than St. Clairsville, or East Liverpool.

Mr. BERTSCHY. Yes.

Senator BROWN. Let me pursue, and Mr. Burke, maybe this is for you. You all talked about the 11 cents a mile, and we all—that's just an embarrassment to all of us. But my understanding is there are some cases where people in the community, particularly someone is driving, they simply can't drive because of their disability, because of their illness, because of whatever reason, they don't have car, and I know that community organizations that support

veterans' groups, sometimes, obviously, veterans service organizations and others will provide transportation. My understanding is, sometimes they are not eligible for reimbursement at all? Someone that's helping. Mr. Burke, if you have to go and you can't drive yourself, and you get some help from somebody in the community, they don't get reimbursed at all. Is there a loophole in the law that disqualifies or some prohibition for reimbursement?

Mr. BERTSCHY. Well, if you're not service-connected, and if you're a Category 7 or 8, if your income is above certain levels, the VA simply says you're not eligible for any reimbursement as far as mileage goes.

Senator BROWN. So if it's Category 7 or 8.

Mr. BERTSCHY. Category 7 or 8, and——

Senator BROWN. Or if you're above a certain income level.

Mr. BERTSCHY. And if you're above a certain income level, and if you're a veteran, but you have no service-connected disability, that is another obstacle to receive——

Senator BROWN. You're eligible to go to the CBOC in East Liverpool, but you can't get mileage.

Mr. BERTSCHY. Correct.

Senator BROWN. Mr. Moore.

Mr. MOORE. You can't get enrolled if you're a Category 7 or 8.

Senator BROWN. You can't get enrolled.

Mr. BERTSCHY. Right now, that's correct. I'm sorry. That's right. Right now, if you're a Priority 8, you can't even get enrolled because they've been locked out.

Mr. MOORE. If I could, Senator Brown. Rural areas are basically, they use HUD for figuring those financial incomes for families, probably for a married couple you're looking at rural areas of about $32,280 for a married veteran, and about $25,000–$26,000 for a single veteran. If he is that income or over that, then he's Category 7 non-service connected, and he's not available, or he's not eligible for healthcare.

If I could, one more. You had asked earlier in regards to outsourcing, why it's another reason why we wouldn't want the VA to do that; because the VA has a unique ability to treat some of these specialized injuries in mental illness that nobody has. Nobody else there in the private sector sees the amputees, and the burn victims, and the PTSD. They've dealt with that for years, and they are the ones with the expertise to really handle and give the best healthcare to those injured individuals.

Senator BROWN. Thank you all very much for being with us and sharing your thoughts, and your experience, and your wisdom. Stay in touch with both of us, personally, stay in touch with the Veterans' Committee in both houses. I will see you all regularly, I'm sure, in the years ahead. And thank you for coming to New Philadelphia, and joining us today. Thanks very, very much.

Mr. SPACE. If I could, before you exit the stage, I just had a couple of things I wanted to bring up. First of all, Mr. Bertschy, I wanted to commend you for what appears to be having logged 85,000 volunteer miles in helping to transport veterans. I got that from your resume, and I wanted to commend you for that.

And if I could just, before we leave this subject, because of the peculiar concerns of rural Ohio when it comes to healthcare; and,

Mr. Moore, I want to address this to you, again, any others feel free to jump in, but I understand your concerns about privatization and pulling funds away from speciality treatment that the Veterans' Administration is able to administer better than anyone else. I think Mr. Bertschy may have mentioned a reference to the prospect of providing local community care for some veterans who don't have immediate access to veterans' care. And, Mr. Moore, are there situations where contracting for healthcare outside of the Veterans' Administration, would be appropriate, and would enhance veterans' care?

Mr. MOORE. Yes. Like I said, with proper use, there are areas I think in need, in rural areas. Obviously, as we talked about, chemotherapy treatment and radiation, even when we have transportation, even in some of our counties to the medical centers at Stokes, when you started getting into that eighth and tenth treatment, you get so ill that just getting on the public transportation, or having to wait for the other guys to come back in a van is just tough on them. Something like that, if we could have it specialized where that and a fee-basis could be outsourced, they get their—obviously, most areas there's somebody, or a medical facility close by that does have chemotherapy and radiation treatment.

Mr. SPACE. So it might be something worth studying, particularly with respect to rural——

Mr. MOORE. Yes, the Veterans of Foreign Wars are not totally against that. We think in certain particulars, it could be of use. But it has to be, obviously, audited and looked over very strongly when you're doing that.

Mr. SPACE. All right. Well, thank you, Mr. Moore. Thank you all of our panelists. I wish we had more time, but we're on a rather tight schedule. When we're through here, I'd ask that you exit the stage, and we have seats arranged for you in the first row. And our second panel will approach the stage. We're going to take about a 5-minute break, and we'll launch into our second panel. Thank you.

[Recess.]

Mr. SPACE. We've got the panelists. I ask that all audience members take their seats. We'd like to move forward with our second panel. Our second panel this morning is Terry Carson, Chief Executive Officer of the Harrison Community Hospital in Cadiz, Ohio, which is in Harrison County.

Mr. Carson, I'm privileged to introduce you this morning both as a panelist and, again, as a constituent. We look forward to hearing your remarks.

STATEMENT OF TERRY CARSON, CHIEF EXECUTIVE OFFICER, HARRISON COMMUNITY HOSPITAL

Mr. CARSON. Senator Brown and Congressman Space, we thank you very much for taking the time this morning. Frankly, you're the only two offices that responded to our letters of issues, so we appreciate you taking the personal time, and also the time out here in the field.

I've been for 15 years attempting to meet the challenges of providing healthcare to rural communities. My background is primarily a big city, Cleveland boy, so when you come out to the rural, there are special challenges that you try to meet because you take

for granted that they're out there, and sometimes, it's a very rude awakening when they're not.

I was drafted in 1965, and I spent my next two years at Walter Reed in Washington, DC. And, of course, I was sort of dismayed when I heard the reports in the papers not too many weeks ago about some of the conditions that have been developing. We know that as a first-class military institution. I don't think that's a veterans' facility. But when I was there, I was a kid coming out of Cleveland, Ohio, never had a stitch, never broke anything, and we were treating and serving the kids that came right in from Vietnam, and many times they had their field bandages on them. So I think it's a system we can be awfully proud of, and I think our entire VA system is one that we can be proud of. But I think the conditions that took place there are probably a good example of you just can't pour money down a rat hole and think it's going to develop into something. Someone has to watch it, and monitor it, and has to make sure that it's working.

And that's really our message in my brief statement that I presented to you folks, is that there has to be a better way to tend to those patients who have critical issues out in the rural communities, without having them go hundreds of miles to a center, because their name happens to be registered there for their treatment.

Sometimes you need to think out of the box, and instead of pouring money into a system that perhaps isn't meeting everyone's needs, how do you come up with ways to make it work? And I was listening to some of the panelists here, and it's very humbling to have gone through my military time without having an injury, and seeing people that have had some pretty devastating things taking place in their lives. But if we can, perhaps, take a little chance to improve the system in the offering that we're giving, maybe it's time well spent.

But it may well be something that you could have a panel of hospitals, and a panel of physicians who are willing to sign onto the VA program, much like we do with the Medicare program in offering these services in various communities. If you want to put your outpatient clinics adjacent to, or in closer proximity to rural facilities, rather than duplicate all the programs. You can just pay for—I know darned well it cost a whole lot less to provide services in Cadiz, Ohio, than it does in downtown Pittsburgh in the VA Hospital. I know because I can't hire the nurses, I can't hire the doctors. We can't afford to hire them away. And perhaps a decentralization approach to this whole thing is one that will make it work a little bit better.

The samples I gave you were those types of patients who come to the hospital with an emergency or an urgent situation in their personal life, and they can't get treatment at our facility because they're on the VA system. We have had problems logistically getting them to the facility because either a bed wasn't available, or the surgeons weren't available to do the work. When we finally did get approval, it is not uncommon for that to be taken and withdrawn, so that patients have to go back to the hospital and spend two or three days at the hospital before they're able to go back up.

I think there's a level of inconsistency with regard to the kind of information that's provided to providers. One might tell you to go ahead and do the service because we'll pay for it over the long haul, and I heard that issue this morning about then the hospital starts dunning the patients because they haven't paid the bill. You could have an arrangement much like the Medicare program where you know what you're going to pay for procedures, and people sign up to do it. That would be an acceptable payment situation.

The other thing is actually getting patients to the facilities. Very often, if a community doesn't have a van service, it is really the responsibility of a family member, or a very good friend. That's not always the best time in their lives, anyway, so friendships could strain pretty thin, when you start going up to these long facilities, and getting someone to take you up and bring you back. So our approach, and our discussion really this morning is the logistics of how to get patients in the system, how to treat them. And when they present themselves as an emergency, it truly is an emergency. It's one that would be an emergency for you, or anyone else who presented themselves with a crisis.

I gave you a specific example of someone who broke their hip, I think three days later before we could ship them up to get the hip taken care of. So our concern is getting those patient's services. We want to do it in a very positive, open way. We think there are opportunities to work together, and I'm really here on behalf of our fellow constituents that we both serve. And we think we do a nice job serving your constituency. We just want to be able to make it easier for their access to it.

[The prepared statement of Mr. Carson follows:]

PREPARED STATEMENT OF TERRY M. CARSON, CHIEF EXECUTIVE OFFICER, HARRISON COMMUNITY HOSPITAL

The Harrison Community Hospital is a Critical Access Hospital serving a population of approximately 15,000 citizens in Southeast Ohio. Included in our service are our veterans that require various levels of care.

The problem that we experience has to do with treating initial emergency/urgent situations and having little success in being able to transfer veterans to the appropriate Veterans' Hospital Center.

Often, we wait days to receive transfer approval, and it is not uncommon for those approvals to be withdrawn during the actual transfer, and change of direction midstream.

These delays do not serve patients well, and often puts the hospital in the position of proceeding with treatment because the care *needs* to be provided. We even have to find alternative facilities to accept the patients, knowing that they too will have difficulty receiving reimbursement for the care.

The simple solution would be for facilities such as ours to be given approval to treat patients in our community and have the local doctors render the necessary care. To be mandated to send patients 65 to 100 miles away during their crisis really doesn't make that patient a priority, just a convenience for the VA Center.

To offer a coordinated system seems to require better access, local treatment or a combination of both.

Thank you for your interest and the opportunity to discuss this important gap in the system.

ATTACHMENT

Patient, 85, was brought to the ER on 02/23/07. Patient had fallen at home and was brought in by ambulance. X-ray showed a fracture of the femoral neck left leg. He had only VA insurance. The VA Hospital in Pittsburgh was called and we were told it was full. Cleveland VA Hospital was also contacted regarding bed availability. They referred him to Pittsburgh since he is a patient of this area. We also called the VA office in St. Clairsville, Ohio, and they stated that he was a patient

of theirs and Pittsburgh. Dr. Sandhu, our ER Physician, spoke with an ER physician, Dr. Ruhl, at the Pittsburgh VA, who advised him to send the patient to that hospital's ER and he would see him. While transporting the patient, we received a call from Pittsburgh VA refusing to accept him, so we had to turn the squad around and bring him back. Dr. Modi accepted the patient and he was admitted here. We were told to call in the morning to see if there was a bed available. The VA hospital was called each day regarding bed availability. On 02/25/07, a comment was made to Pat Worrell (Nurse Manager) by Mr. Anderson, AOD, Admission's Director, that "possible transfer on Monday, transfer may cause further damage to fracture". He also said that "they are using too much of the OR time on bones, this is a regional center for kidney and liver and they are getting bones from everywhere in the region". Dr. Modi attempted to get another orthopedic physician to accept the patient. He finally got in touch with one at UPMC who agreed to accept the patient, but the hospital wanted the patient to be counseled and sign a form, witnessed, stating that he may be responsible for the bill before accepting the patient. After speaking with Administration at the VA Hospital and again to the St. Clairsville VA Clinic, we were notified that the Pittsburgh VA Hospital had a bed and the patient was transferred on 02/26/07.

Patient, 75, came to the ER on 02/28/07. Found unresponsive at home with a blood sugar of 22 and respiratory problems. He was diagnosed with sepsis, hypotension, dehydration, hypoglycemic reaction and acute pyelonephritis. He required large amounts of IV fluids to maintain BP. Attempted to transfer the patient to the two VA hospitals but both did not have any beds. Also attempted to transfer the patient to several local hospitals with East Ohio Regional Medical Center agreeing to take the patient.

Patient, 35, came to the ER with suicide ideation. He did not have any insurance and his mother stated that he had been at the VA Hospital in Pittsburgh before. We called that hospital and they put his name on the list, they did not have a bed and we were to call every day to see if a bed was available. Pam Parrish (Social Services) contacted Chuck at the Cadiz VA Office requesting assistance to find a bed. He called the VA Hospital, and also was told the same thing, no bed available, his name was on the list, and they would try to get him in as soon as possible. We also tried the Cleveland VA hospital and left a voice mail, but no one called back. The patient was eventually transferred to Belmont Community Hospital's Mental Health Unit.

Senator BROWN. Thank you, Mr. Carson.

Dr. Gerald Cross, who's been with the VA for many years, is now the Acting Principal Deputy Under Secretary for Health.

We appreciate your coming to New Philadelphia, and speaking with us today, Dr. Cross.

STATEMENT OF GERALD M. CROSS, M.D., ACTING PRINCIPAL DEPUTY UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS AFFAIRS

Dr. CROSS. Senator Brown, thank you very much for having me here, and I want to say I'm a family physician. I grew up on a farm in a rural environment in Virginia. I was a member of the 4-H Club, and I guess those are my best credentials. I'm here with Jack Herrick, Director. Jack, can you stand up so people can see you. And we've already had a chance to talk with Mr. Carson this morning, so this meeting has already served a purpose in that we started the channels of communication to work out some of the issues that he's talking about. And, by the way, we'll continue that.

I've ditched my speech, and I've just written down a few notes I want to comment on, based on what I heard this morning. Rural healthcare is, in fact, very important to us. It's about 39 percent of our enrolled population for healthcare. And, indeed, we have established and are developing an Office of Rural Health at the Central Office in Washington. But much more than just creating a new office in Washington, I want to tell you what we're really doing that's making a difference.

Strategically, we are doing geographic dispersion. We were very much a tertiary big medical center-based organization a decade or two ago, and we're changing dramatically, much more to continuity, comprehensive care, outpatient care, primary care. And we followed through on that. We now have 717 community-based outpatient clinics. We're planning 20 or more of them for 2007, and more for 2008; 207 Vet Centers, and more planned in the coming years. These wonderful organizations that are so accessible in terms of lack of bureaucracy, just walk in and say hello, and somebody there will say hey, welcome. Sit down, have a cup of coffee, let's talk.

Telemedicine and mental health, to make sure that we can do specialty consultation, diagnosis, follow-up even at our small community-based outpatient clinics of some our specialists, like dermatologists, or mental health, especially mental health.

And we don't expect our patients who get medicine every month for blood pressure, cholesterol, or whatever to have to come to the pharmacy of the big medical center, or even at the CBOC. We mail it to them. We deliver the medicine to the home wherever that home may be, month after month, year after year.

And we're moving into a new direction, home-based primary care, where we actually send providers out to the home to take care of people who are restricted to the home and unable to get up and about; $175 million in our 2008 budget just for that one program, and many millions of more for other similar, related programs.

So here are the results at the moment. Within 60 minutes of care nationwide, 92.5 percent of our enrolled population for healthcare. Within 90 minutes nationwide, it's 98.5 percent. Mental healthcare is especially interesting. In 1996, the average distance traveled for mental healthcare was 26 miles by a veteran going to a VA facility. It's now 13 miles, approximately.

Satisfaction among our patients in the rural environment exceeds that of those in our urban environment. Quality of care is measured by standard indicators, of which we have many. Almost exactly matches, on average, that's received in urban care.

Now, sir, I'd like to say just a word about OIF and OEF. The secretary some years back opened two years of eligibility for anyone returning from the combat theater, that includes OIF and OEF. The two years of eligibility that the secretary opened sometime back for OIF and OEF still makes it possible for an individual coming back from the combat theater to get the care they need, and gives them time, if they're going to go through a disability process, to get that disability claim done. I should say that in the Senate right now, there is a bill to extend that two years to five years. And I testified, I think about two weeks ago, that we were in support of that.

We're adding staff, doctors, nurses, psychologists, especially mental health staff. We're screening everyone coming back from the combat theater OIF and OEF for TBI, Traumatic Brain Injury. This is something the VA does better than anyone else, because of our comprehensive electronic health record. And we're doing the same thing for PTSD. We're doing the same thing for substance abuse, and we're doing the same thing for depression.

We're the only organization, I believe, that can make those statements. And then we're going to follow-through on them. We're doing research to find out more about these conditions, as we've done a tremendous amount of research, for instance, on PTSD. But I want to tell you about two new things, just very briefly, and that will be my conclusion.

Transition Assistance Advisors are in place in every state working through the National Guard in the Office of the Adjutant General, right in the Governor's office. The states can provide services that on a federal level, we don't really do, such as providing employment, providing link-ups to the local community to find employers ready to hire these returning veterans. And these individuals in the Governor's office also help to make sure that individual is aware of all the state services, and all of the federal services.

And something very new, and I want you to know about this. Transition Patient Advisors, a hundred of them being GS–11s, don't have to be medical care workers. We're putting them in Ohio, and every other state. And when a new veteran seriously injured shows up at Walter Reed or Bethesda, they fly there to meet with them, to meet with the family, to follow them a couple of times a week, and to make sure that there's no falling through the gaps. That concludes my statement, sir.

[The prepared statement of Dr. Cross follows:]

PREPARED STATEMENT OF GERALD M. CROSS, M.D., ACTING PRINCIPAL DEPUTY UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS AFFAIRS

Good Morning, Members of Congress. Thank you for the opportunity to discuss VHA's ongoing efforts to provide safe, effective, efficient and compassionate health care to veterans residing in rural areas.

My remarks will briefly review the national challenge presented by rural health care, VHA's strategic direction and initiatives underway.

Among the entire enrolled VA population, 39 percent were classified as rural at the end of FY 2006. And among the entire enrolled VA population, 2 percent were classified as "highly rural." Highly rural refers to counties with less than 7 citizens per square mile.

Researchers have studied the rural health care experience, including a number of articles that looked at VA rural healthcare. Three studies have found that veterans living in rural areas tend to be slightly older, and more likely to qualify in Priority group 5—that is, non-service-connected, zero percent service connected, and low income. These same veterans were also less likely to be employed. The studies agree that rural veterans had slightly more physical health problems but fewer mental health conditions—as compared to suburban and urban veterans.

VHA's strategic direction is to enhance non-institutional care with less dependence on large institutions. Instead, we are providing more care at home and in the community.

VHA now has 717 Community Based Outpatient Clinics or CBOCs. Of this total, 320 or 45 percent of these are located in rural or highly rural areas. We've created Consolidated Mail-Out-Patient Pharmacies or CMOPs so that medications are delivered to the patient's home—instead of having the patient travel to the hospital. We provide home based primary care—devoting more than $175 million to this program in FY 2008, and more than 95 million dollars for other home based programs. We are using tele-medicine and tele-mental health to reach into the veterans' homes and into community clinics. This allows us to evaluate and follow patients without them having to travel to large medical centers. We are far along with our mental health enhancement initiative that will add resources and greater mental health expertise in primary care clinics. We are also using a special Internet site, providing information to veterans in their own home, including up-to-date research information, access to portions of their medical records, and the ability to refill medications online.

To accomplish this, VHA is emphasizing primary care and spreading out geographically. At the end of FY 2006, 92.5 percent of our 5.4 million patients were

located within 60 minutes of a VA healthcare facility. And 98.5 percent were within 90 minutes. Among those who live outside the 60-minute range, some are those veterans in highly rural areas and some are veterans living in Tribal areas.

In 2006 evaluations of veteran patient satisfaction, comparing rural versus urban veterans, we found that rural patients were more satisfied with their health clinics than their urban counterparts.

We also looked at the quality of care, comparing rural versus urban clinics. Looking at 40 standard measures, quality was virtually identical overall between rural and urban clinics.

To continue this strategic support for access and rural health care we have over 20 CBOCs for 2007. Forty three percent of these CBOCs are in rural or highly rural areas. In addition to these clinics, VA is currently working on telecommunications strategies to provide Care Coordination/Home Telehealth services in rural areas. Since January 2004, VHA has trained over 3,500 staff nationally to provide care via CCHT.

In Ohio, there are 5 VA Medical Centers and 32 Community Based Outpatient Clinics (CBOCs). In close proximity to Appalachia, (the region in the United States that includes the southern Appalachian Mountains, extending roughly from southwestern Pennsylvania through West Virginia and parts of Kentucky and Tennessee to northwestern Georgia) we have 9 CBOCs in Southeastern Ohio and 2 in Kentucky. Specifically, East Liverpool (Columbiana County), New Philadelphia (Tuscarawas County), Athens (Athens County), Lancaster (Fairfield County), Cambridge (Guernsey County), Marietta (Washington County), Portsmouth (Scioto County), Batavia (Clermont County), and Zanesville (Muskingum County). The 2 (two) Kentucky CBOCs are in Bellevue (Covingnton, KY) and in Florence, KY. These CBOCs are located in rural areas of Ohio bordering southern Pennsylvania, West Virginia, and parts of Kentucky.

In addition, the Vet Center program provides quality readjustment counseling and removes unnecessary barriers to care for veterans and family members. Vet Centers engage in extensive community outreach activities to directly contact and inform area veterans and to maintain active community partnerships with local leaders and service providers to facilitate referrals for veterans in need.

Some Vet Centers are maintained in rural areas to ensure that rural veterans and families have access to readjustment counseling services. Additionally, we have established Vet Center outstations in rural areas. Outstations are administratively connected to a full sized Vet Center, use permanently leased space and are usually staffed by one or two counselors who provide full time services to area veterans on a weekly basis. The Vet Centers also maintain nontraditional hours to accommodate veterans traveling in from greater distances.

Vet Centers in Wheeling, Parkersburg and Huntington, West Virginia all located on the Ohio River provide outreach and readjustment counseling to veterans in rural Ohio.

In addition to our internal efforts outlined earlier, VA continues to look for ways to collaborate with complementary Federal efforts to address the needs of health care for rural veterans. We also have partnerships with HHS, including the Indian Health Service and Office of Rural Health providing health care in rural communities. We are also working to establish relationships with other entities, such as with the National Rural Health Association.

VHA recognizes the importance and the challenge of service in rural areas, and we believe our current and planned efforts are addressing these concerns for our current and emerging veterans.

This concludes my statement. At this time I would be pleased to answer any questions that you may have.

Mr. SPACE. Thank you, Dr. Cross, and I apologize for having to cut you off. We are running short on time.

Incidentally, I think the Patient Advocate Program you just referred to is still in its early stages, but I think it's a very valuable addition to the Administration.

I want to talk a little bit about the CBOCs, again. And you had mentioned that there are plans to build more than 20 right now. Do you have any indication, if the 18th Congressional District for the State of Ohio will receive any additional CBOCs?

Dr. CROSS. For Ohio, I think there were two, and, Jack, you can help me with this. I think one is in Hamilton, and the other is——

Mr. HERRICK. Hamilton and Parma were announced this week.

Mr. SPACE. Oh, Parma and Hamilton. So that will not facilitate or enhance the care of veterans in southeastern Ohio. And, second——

Dr. CROSS. We do have other options besides CBOCs.

Mr. SPACE. Right.

Dr. CROSS. Outreach Clinics that work for a CBOC, that can go into communities. Often they lease space, and we have a number of these now. And they're not listed as CBOCs, but they can be open for a day a week, or a couple of days a month, and provide services for those very small groups of veterans in these more remote communities. And we're doing that more and more.

Mr. SPACE. Right. Now I understand last week we passed legislation that will allow for mobile units to enhance TBI treatment and care in rural areas, which is also an encouraging sign. But the fact remains that many veterans in rural Ohio are having to do things like travel 80 miles for radiation treatment, and then 80 miles back home again. And as Representative of this area, I'm trying to ascertain means by which to help solve those problems associated with veterans care. And I can't help but get around what may be, to me, an apparent need, seemingly a need for the construction of additional medical centers, those primary care facilities that render services of a broad range to veterans. I understand you can't build one in every county.

We've got 16 counties in my District, we've got five CBOCs servicing those counties, and many residents in my District, who require specialized care, of course, drive 70, 80, 90, even more miles to receive care. Do you see a perceived need for the construction of a medical center in southeastern Ohio?

Dr. CROSS. To tell you the truth, sir, I don't know, because the CARES process that we've gone through, I want to refer to that and see what the findings were from that. That's a piece of information I can certainly get for you.

Mr. SPACE. You would agree with me that veterans in rural areas of America, and specifically in Ohio, do suffer from a lower standard of care than those veterans in urban areas, simply because of their proximity, or lack thereof, to those medical centers.

Dr. CROSS. I don't agree with that for the VA. We've done the statistics on the performance measures related to the quality of care.

Mr. SPACE. I'm not talking about the quality of care.

Dr. CROSS. Absolutely. I understand what you mean. I certainly do share that, the access issue by itself. I do need to put out one cautionary comment, talking about radiation therapy. Radiation oncologists and the equipment that goes with radiation therapy is something that wouldn't be found, necessarily, in the rural environment anywhere. And so that's a real challenge for us, and for everyone else in the civilian community, in Medicare, and so forth, to deal with those special circumstances. And I think the VA is, in fact, flexible about this. And on a case-by-case basis, can make arrangements to do what's best for the veteran.

Mr. SPACE. And just as a brief follow-up, I mean, it is a fact, is it not, that rural Americans have shouldered more than their fair share of not just this war, but wars past, as well. Correct?

Dr. CROSS. Sir, I expect that that is true.

Senator BROWN. Thank you both, again. Monday, in celebrating Memorial Day, there were a couple of numbers I wanted to bounce off you, Dr. Cross, and ask for your thoughts on. Something along the lines of the Harper's Index, that they use that as sort of the box, 27 percent of veterans of the War in Iraq and Afghanistan have filed for disability with Veterans' Administration, and these are the two upcoming numbers that I think are the most significant. Ten percent of soldiers given medical discharge in 2001 were given permanent disability benefits, but only 3 percent of soldiers given medical discharges in 2005, who got permanent disability benefits. Why would that be, that 10 percent of those not in wartime who left the military were getting permanent disability benefits, but only 3 percent of those discharged in 2005? Do you have any thoughts about that?.

Dr. CROSS. I think my response would be it's early, and over time, we'll get a better picture of what their real pattern is going to be. I think it may be a bit premature to say what their long-term disability outcome is going to be, at this point.

Senator BROWN. Sir, maybe that's right, but I'd be more likely to accept that if the military were not doing a bit of a better job, certainly a better job than contrast to Vietnam, when several people from the last panel came home from Vietnam, they, one, weren't welcomed home in too many cases. But, second, certainly didn't have the kind of interaction with the VA, to talk to them about any kind of physical or mental injury they might have had. Today, we're not doing a splendid job, but we're doing better, as you suggest with some of your outreach. So shouldn't those numbers be higher as a result of that?

Dr. CROSS. Again, I think individuals don't apply for disability necessarily right away. There's no limit, there's no time limit on when a veteran can apply for disability. We've seen veterans applying for disability now for Vietnam.

Senator BROWN. And we're seeing people now from Vietnam, because of the attention paid to Iraq, I know. And I know those numbers are again going——

Mr. CROSS. So I think——

Senator BROWN. I would like to explore this more. Let me shift to continue questioning, for you, Dr. Cross, but particularly about Mr. Carson's issue. We've heard from him that community hospitals and patients are faced with unreimbursed care when after stabilizing emergency patient, they can't transfer them to a VA facility because there are no beds available in a county as rural as Cadiz and Harrison County. We're looking at legislation to ensure that this doesn't continue, but two questions. Why is this happening, in the first place? And, does the VA actually have the discretion to pay these claims? I guess a third question then, if the answer is no, is legislation necessary?

Dr. CROSS. There is legislation that relates to the Mill Bill. I forget what year that was, I think it was about 2000, which sets up emergency care funding for situations where an enrolled veteran who has been seen within the previous 24 months, if I recall correctly, is eligible so that they can go to the nearest emergency room and get care. We didn't want a situation to occur where a person

is having a heart attack and drives past the community emergency room to get to a VA facility which is some further distance away, which would not be to their advantage in that situation. So the Mill Bill created, as I understand it, a possibility to get that care delivered and covered for a period of about three days, the intent then being to transfer them back to a VA Medical Center.

What I'm hearing this morning, though, I think, and that's the value of this hearing, especially to make these kinds of link-ups, is that we have some communication issues with Mr. Carson's hospital. And I've got my VISN Director here, and other staff to make sure that we work some of those out to deal with those issues that he's pointed out, and very appropriately pointed out.

Mr. SPACE. Given the late hour, I just simply don't have much more time for questions. Your testimony will be entered into the record.

Dr. Cross, I'm going to revisit, as my last question; and that is, given, once again, that we've got a very large area in southeastern Ohio served by, what I understand to be about 65,000 veterans who are living here right now. We've got five CBOCs in 16 counties, and admittedly, those rural veterans are suffering from a lower standard of care, simply because of the drive time to and from medical centers. My request of you is that you take measures to inquire with your superiors, and conduct a research study whether or not this area of Ohio would be a suitable and appropriate location for the construction of a VA medical center.

Dr. CROSS. Yes, sir, we'll do that. And I would like to also say that we will be delighted to meet with your staff, and sit down and discuss any issue that you'd like directly.

Mr. SPACE. Thank you, Dr. Cross. Mr. Carson, briefly.

Mr. CARSON. Congressman Space, just one comment on that, for what it's worth. I mean, you can look at a map and say well, it's just 20 miles, but for those of you who drive the District, and the limit is 55, I challenge you to get up to 55 miles an hour on some of these roads, so that really——

Mr. SPACE. Point well taken, Mr. Carson. I'd like to thank you both, again, for your testimony.

Senator BROWN. One question, before you close off, if I could. And thank you, Congressman Space, I've thought for some time that the VA is, in fact, I think probably so the best healthcare, when we fund it, the best healthcare in the country in terms of medical, lowest numbers of medical errors, outcomes, the specialty and the general care that the VA gives. I've also seen a commitment, and with some results so far of a much better coordination. A commitment from the Secretary with a much better coordination from DOD and to veterans' healthcare, because it's been uneven, at best, over the last years, and I give the VA credit for that.

But then I see the message that it sends to our troops, to our men and women in uniform, when the President and Secretary Nicholson ask for a budget billions of dollars less than the Independent Budget that the veterans service organizations ask for, and they brag to our Committees in both houses that we're spending, I think the number they say is 77 percent more than 2001. Well, yes, but there's been not, certainly new Vietnam Vets coming on line, coming to the VA, that weren't coming before, and certainly

from this war. So I just would ask you, Dr. Cross and Mr. Montague, to take back to the VA the message that sends to our men and women in uniform, when we're willing to spend $2.1 billion a week on a war, and we're not willing to fund to the level with the Independent Budget in mandatory funding of the VA. And I know you, as a physician, probably agree with much of this, but take that message back, how important that is.

So I thank you both for being here, thank you to our panelists. And thank you all who have joined us. Why don't you close it off, Congressman Space.

Mr. SPACE. Thank you, again, Senator Brown. Thank you to the panelists, both in the first and second panel. And thank you to everyone who came out today in the interest of the State's rural veterans.

Again, I'd like to send a special thanks to Dean Andrews and his team here at Kent State for hosting us. Thank you to my veterans' Advisory Board for their continued direction and knowledge. And thank you to our witnesses, once again, who have traveled to get here and present their views, so that we can all recognize the serious issues that stand in the way of rural veterans obtaining comprehensive care, and access to VA services.

Where a veteran chooses to live should not affect his or her access to care. Our country is committed to provide healthcare, educational, vocational, and other services to our Nation's veterans, and we must follow-through on that promise. Telling a veteran that his home, or her home, falls into a geographical region that is not cost-effective to serve is not in line with keeping the promises previously made to our country's heroes. A veteran from rural Ohio gave just as much in service to our Nation, and sacrificed just as much, as a veteran from New York City, Los Angeles, or Cleveland, Ohio.

This hearing has given us valuable knowledge about how Congress can move forward on important issues facing rural veterans. This hearing has brought together many of those who are directly involved in caring for these rural veterans, who make up approximately 40 percent of our Nation's veterans population. I'm extremely optimistic that given the ideas that we've heard today, Senator Brown and I will be able to move forward with innovative solutions, including legislation. I plan on working with Members of the House Veterans' Affairs Committee, as well as my colleagues on both sides of the aisle, to advance the agenda of rural veterans.

Today, the day after Memorial Day, we've met to discuss how to move forward in better caring for those who have served our Nation. Let us also remember to look back on where we've come from. Let us remember those brave servicemembers who have given their lives in defense of our Nation; 16 from this District in this most recent war.

I wish, also, to thank the veterans in our audience, the men and women currently serving, and their families who support them, for their past and continued service and sacrifice. It's an important honor to work on your behalf, and please know that I will continue to do so for as long as I serve in Congress. Again, thank you all for being here. Thank you, Senator Brown.

[Applause.]

[Whereupon, at 12:02 p.m., the joint hearing adjourned.]

○